

COUNCIL ON DIAGNOSIS AND INTERNAL DISORDERS
OF THE AMERICAN CHIROPRACTIC ASSOCIATION

THE CHIROPRACTIC FAMILY PHYSICIAN

NOVEMBER 1978

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MEMBER

1978

**Council on Diagnosis
and Internal Disorders**

of the

AMERICAN CHIROPRACTIC ASSOCIATION

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THE CHIROPRACTIC FAMILY PHYSICIAN is published quarterly by the Council on Diagnosis and Internal Disorders of the American Chiropractic Association, Journal Office: 11411 Victory Boulevard, North Hollywood, California 91606.

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Contributing to The Chiropractic FAMILY PHYSICIAN

The Chiropractic FAMILY PHYSICIAN solicits professional articles which are clinically oriented in either diagnosis or therapeutics of constitutional or systemic disorders. We are as concerned to recognize abnormal functions as well as pathology in both diagnosis and treatment. We recognize that very little attention has heretofore been directed to abnormal functions as distinctive from pathology. As to preventive therapeutics, it seems to be obvious that by turning our attention and our efforts toward restoring and maintaining normal physiology, most of the important aspects of prevention are adequately provided.

We intend to furnish the doctor of chiropractic who reads this Journal sound clinical information which will enable him or her to work effectively in practice and to gain new information which will give them the confidence to accept and successfully handle a wider scope and range of cases than would have been possible without this Journal. The Journal will feature a 'Clinical Roundtable' and invite practicing doctors to contribute written or taped cases they have taken care of which may help other doctors with similar cases. We believe that a great number of doctors have evolved, through their clinical experience, valuable information which should be shared with their colleagues. This Journal is essentially clinical with as much emphasis upon diagnosis as upon therapeutics. Technical non-clinical articles must have obvious clinical applications.

If manuscripts for the 'Clinical Roundtable' are somewhat unpolished, the Editor will reserve the right to 'polish' them enough to be creditably readable. Scientific articles will be expected to be written as the author would want them to appear in the Journal. All manuscripts must be neatly typed and spelling carefully checked.

Please consider this as our invitation to you to assist us in promoting the advancement of chiropractic. It is increasingly imperative that we be recognized as true portal of entry physicians. By the type of articles we have indicated above, we will be encouraging the field practitioner to expand his or her practice. We need your help in this educational process with your good articles. Please join with us in this effort to advance our profession.

The Editor
The Chiropractic FAMILY PHYSICIAN
11411 Victory Boulevard
North Hollywood, California 91606

**THE EDUCATIONAL AND CLINICAL COUNCILS
OF THE A. C. A.**

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2. Mental Health
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4. Nutrition
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6. Physiotherapy
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July – 1978

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Dr. Dean C. Palmateer
Dr. Ralph J. Martin
Dr. Glenn L. Olson
Dr. Robert Wiehe
Dr. Jay D. Kirby

Alternates

Dr. William A. Nelson
Dr. Casmer Nedzweck
Dr. Harry O. Davies
Dr. Adrian Overbeck
Dr. Jeffrey Greene

THE PHYSICAL EXAMINATION

The physical examination performed by the Chiropractic Family Physician is unique in the field of health services. He not only is proficient in all the standard procedures relating to a medical physical examination but is also skilled in relating all the systems of the body to one another. He makes a distinction between the diseases of abnormal function and those of pathology. He has learned how to interpret surface findings on the body to internal disorders. He is very careful to get the patient's full history and relates the history and physical findings to guide him to determine the need for X-rays and Laboratory tests and profiles. Through his careful physical examination he usually knows where the problem is, then if tests are to be made they are for the purpose of evaluation of all physical and biochemical factors. By his very careful physical examination he is able to avoid many unnecessary laboratory and X-ray procedures which is a substantial economy to the patient and avoids excessive radiation.

The X-ray Examination

Most chiropractic family physicians have their own X-ray equipment for several reasons:

1. They have many emergency cases which call for immediate X-rays and prompt interpretation which could not be sent out to independent laboratories without great loss of time.
2. Cases requiring immediate X-rays may involve possible broken bones, spinal injuries or internal crisis.
3. Many cases requiring prompt X-ray service may involve internal emergencies such as gall stones or rupture, malfunctions of the stomach or duodenum or ulcers, kidney stones and acute malfunctions, bowel crises, brain injuries and tumors. Doctors expecting to become family physicians must be trained in X-ray technics of internal disorders as well as musculoskeletal disorders.
4. The need for local practitioners to provide screening facilities is an

important saving in the over-all cost of health care. Great proliferation of costs in expensive hospital facilities can be avoided by local private-office X-ray services.

Laboratory Diagnosis

1. Chiropractic family practitioners must acquire expertise in laboratory procedures and interpretation above and beyond usual undergraduate training.
2. Many will have to provide their own laboratory services; all will have to be familiar with a very wide variety of interpretative skills.
3. Frequently the family physician may be required to provide or procure preliminary laboratory profiles before he can determine a suitable specialty service for referral.
4. Experienced practitioners recognize that a very high percentage of the patients they see have problems of abnormal function rather than diseases of pathology. The chiropractic physical examination will usually clarify this distinction, but a sedimentation rate fortifies the validity of the finding.
5. Laboratory findings alone are generally recognized not to constitute a diagnosis. This is the great contribution of the chiropractic family physician "who puts it all together". He considers the patient as a person and his history and physical findings have directive influence on the X-ray and laboratory profiles so that his final diagnosis determines whether he will treat the patient himself or refer . . . which ever is in the patient's best interest.

Methods of Treatment Utilized by the Chiropractic Family Physician

1. All manipulation is to correct nerve and vascular disorders caused by structural pressure and mal-positions. The chiropractic family physician uses any form of manipulation that will provide a return of the patient's body to normal function. He may manipulate the spine, pelvis, ribs, skeletal joints of any of the extremities, or even

of the skull. He will probably be skilled in highly sophisticated adjustments of the neurovascular systems which will profoundly improve the functions not only of the internal organs and systems but also of the brain and emotions. He will be able to treat defects of new-born babies and children to overcome birth injuries and defects. He will treat the elderly for high blood pressure and strokes with surprising success that is totally unheard of in medicine. He will be able to stop the vomiting of pregnancy and alleviate the horrors of menstruation which many women suffer . . . all without drugs with his knowledge of nutrition and skill in manipulation.

2. **DIET AND NUTRITION.** Nutrition and food specifics are the wave of the future in human therapeutics. As the iatrogenics of drugs and medicine are better understood and the hazards more widely known to the general public there is a great turning away from them as they have been accepted for the past century. Patients have a strongly developing attitude that "there must be a better way". He does not deny that drugs, medicines and surgery are useful but he prefers to keep them in their proper place and refer to their use as a last resort. The body should be assisted in restoring its own normal functions without the introduction poisons from the external which often compound existing problems. When the resources of the body cannot rise to meet a crisis, we then utilize whatever measures may provide further help and assistance.

Modern nutrition involves much more than organic vegetables and whole grains at the health-food store. Nutrition involves complete balance of ingredients: proteins, carbohydrates, fats, vitamins, minerals and enzymes and in some cases glandular products. Diagnosis and treatment of nutritional requirements demands well trained chiropractic family physicians and these cases may compose a considerable element in his practice.

3. **PHYSIOTHERAPY.** The chiropractic family physician is usually well equipped with standard physiotherapy modalities including

well equipped with standard physiotherapy modalities including heat lamps, diathermy, ultra-violet units, ultrasound, galvanic and sine units, vibrators and traction units. Each modality has its own special indications and contra-indications. Ultraviolet is highly effective as a bacteriacide. Ultrasound is an ideal decongestive agent and relieves many forms of pain. There are many special ultrasound applicators. The use of ice (cryotherapy) as an anesthesia is a very significant aid to the chiropractic family physician who avoids drugs for sedation. Sine wave is highly effective in many circulatory problems. Galvanic has a multitude of uses in infiltrating tissues with specific chemicals, or without chemicals. Dr. A. C. Johnson's latest book "Chiropractic Physiological Therapeutics" should be a ready reference to every chiropractic family physician.

4. **PSYCHOTHERAPY AND EXERCISE.** All accredited chiropractic colleges provide comprehensive courses in clinical psychotherapy for all their graduates. The Council on Diagnosis and Internal Disorders also gives strong emphasis to this field of therapy in the Syllabus required for the examinations for Qualified Internists and Diplomates. Chiropractic family physicians of experience have learned that a great many of their less seriously ill patients show symptoms of lack of daily physical exercise and suffer periods of depression which are linked with failure to get adequate daily exercise. These physicians provide exercise programs which are suitable for the age and physical condition of their patients and thereby eliminate many of the less severe problems of psychotherapy.

These doctors also recognize that the mind represents the functioning of the brain and therefore provide instruments of testing of blood and fluids in the brain and treat to maintain normal fluid balance within the brain. Thereby many psychotherapeutic problems are eliminated. Concern with improvement of the physiological factors affecting the brain is also opening up a whole new field of treating expertise which not only improves the mind but also many physical ailments are benefited.

All of these things are completely within the field of the practice of the chiropractic family physician.

Referrals and Cooperation With Other Practitioners

1. The chiropractic family physician learns to know as much about all available professionals in the health field in his area as possible in regard to their competence, responsibility and reliability. This is his social responsibility so that a patient will be referred for special services to one who is not only cooperative but meets the criteria listed above. Referrals on this basis will not only enhance the status of the referring physician, but will help to build a climate of cooperation and mutual respect among all health professionals in the community.

A STATEMENT OF POSITION of the Council on Diagnosis and Internal Disorders:

"A Chiropractor should be able to care for any condition which may arise in the families under his care, the same as a physician." D. D. Palmer, in *The Science, Art, and Philosophy of Chiropractic*, page 789. Today this is even more timely than in 1895, for now we have a long tradition of serving as family physicians and primary providers of health services. It is now particularly important that we serve as primary health providers in fact as well as in name for now most of the time there is a third party involved, either an insurance company or a governmental agency. If we drift into a scope of practice which is limited to musculoskeletal conditions, third party payors will insist that we are not truly primary providers and put on pressure to down-grade us to treating only referrals from real primary providers. We are already getting pressure from all sides to classify ourselves as back technicians only and for several years have required diagnosis but deny payment for it, which means they refuse to recognize our expertise in diagnosis. The prevailing situation in Medicare and Medicaid is intolerable and unless we assert ourselves as primary providers, in fact as Chiropractic Family Physicians, we may soon wake to find that we have less professional status than the paramedics.

Only as we assert ourselves as chiropractic family physicians in every sense will we survive as doctors in any sense or substance. As back and musculoskeletal technicians our future as a profession is bleak and possibly terminal.

If we are to have a future as a professional we must awaken now to our responsibilities as chiropractic family physicians.

**SYLLABUS FOR EDUCATIONAL HOURS REQUIRED
TO TAKE THE EXAMINATION
FOR "QUALIFIED INTERNIST"**

1. Educational Requirements to take the Examination for "Diplomate" Same as for Qualified Internist but in greater depth and much more clinical work and special subjects and technics.
2. Residency Courses only in Accredited colleges leading to "Diplomate" status, requiring clinical residency experience in addition to attending the 302 hours of academic Syllabus above outlined for "Qualified Internist."
3. Special Educational Seminars for general membership, in colleges or local regional areas.
4. Educational meetings for student units of the Council on a monthly or by-monthly basis as needed.

CONGRATULATIONS



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HEALTH SERVICES IN AMERICA

1. Diagnosis is the first step for a patient to enter into any phase of health service.
2. For this obvious reason Chiropractic Family Physicians must develop an image in the public mind of special expertise in diagnosis.
3. We already have a basis for this but it must be perfected and made known regarding our association of internal disorders. We have to stop only concerning ourselves with the structural problems.
4. In the field of therapeutics our graduates must be prepared to work in the field where there is the greatest need. This is the area of the Family Physician. Statistics clearly show the flight from "general practice" in the medical field. Practically all geographic areas are sadly lacking in "general family practitioners."
6. In this era of specialty proliferation the patient needs diagnosis first and, second, "someone who can put it all together" before he or she sees any specialist.
7. This is made to order for properly trained chiropractic family physicians and there are untold thousands of opportunities for chiropractic graduates who want to provide this broad scope of services.
8. Statistics on the overabundance of specialists and scarcity of general family practitioners are overwhelming.
9. The chiropractic family physician provides a unique and effective public service and does not need to prescribe drugs. When drugs or surgery are properly indicated by the diagnosis, he refers the patient for these services and builds a climate of cooperation and respect with the other health professionals.

EDITORIAL

By Dr. Richard Tyler

Chiropractic is the science of health regulation as it pertains to the maintenance of the structural integrity of the spine and other articulating surfaces of the body. That's a simple definition - one that we should all be able to find some measure of agreement in. Unfortunately there are almost as many interpretations of what we do to achieve that integrity as there are people who practice the art. One can hardly go to the mailbox or read a professional journal without being assailed by the glories of some very "special" technique. Each promulgator of his method either directly or by inurement seems to look diversely at his competitors. It's nice to believe that what you do is right but I feel that there are elements of value in just about all of the more accepted as well as estoric therapeutic approaches. We should study or at least be exposed to as many researched opinions as possible. Naturally the differences of therapeutic concepts within a particular healing arts discipline isn't indigenous to chiropractic. Chemotherapeutic and surgical conceptual dichotomys within medicine have been historic.

One thing however has been common to all the healing arts. When a patient comes to you for help how do you decide what is wrong so that you may make assumption upon which to base your therapy? In other words how can we correct a problem unless we can determine a cause? Elements within chiropractic subscribe to a concept that loss of "structural" integrity causes a mechanical abbarance which in turn causes a neural malfunction, followed by "disease". Within that concept I'm sure that there are many other concepts until things begin to reflect some kind of intellectual as well as therapeutic confusion.

Some things however, should be obvious to any thinking individual. There can't anymore be a "standard" cause for a specific illness any more than there can be a "standard" human being. Just as there are no two fingerprints that are the same so too there are no two people who will react in the same way to a specific set of conditions.

We haven't a therapeutic panacea. Osteopathy doesn't either. If allopathic medicine did we wouldn't need to be around because all of man's ills would have been cured a long time ago. By the same token medicine would have died if we had had all the answers. Obviously we all have some therapeutic validity and if we work together a little more assiduously we should be able to help more people.

All of this pertains to a specific philosophical acceptance of a specific therapeutic concept. That's fine. One can hardly debate a philosophy because a philosophy like religion is based on "faith" that what we think is correct. But what about the poor patient? He doesn't care about philosophies or all the semantical nonsense we get ourselves quagmired in. He doesn't feel well and he'll give you some money if you'll just make him feel better. It is at this point that we must discard our philosophical differences regarding therapy and approach each living being that comes to us for help with as many diversified diagnostic approaches as there are individuals. Monitoring and assessing the findings of specific body functions based upon generalized parameters of the average individual may not be the perfect way to find out what is wrong with the patient and why, but it's probably the best until a race of clones is established.

Over the years some very sophisticated diagnostic procedures have been developed. It is the duty of all physicians, whether they be chiropractic, osteopathic, allopathic or naturopathic, to utilize as many of these procedures as possible to best establish a cogent therapeutic base. After that a philosophical energy regarding the therapy can and should be applied.

The exposure of the chiropractic physician to as many diversified diagnostic procedures as possible is what this publication is all about. It is our hope that this will be a "thinking" journal because what will be postulated will be varied diagnostic procedures with debatable conclusions. The cerebral exercise from exposure to information is bound to strengthen us as physicians. From a pragmatic standpoint we *must* become good diagnosticians if we are to become a portal of entry into a national health program instead of prescription item on a medical pad. What is just as important is that we need as much diagnostic acumen as possible to best serve those who place their health in our hands. To do less is a blasphemy to our oath as members of the healing arts.

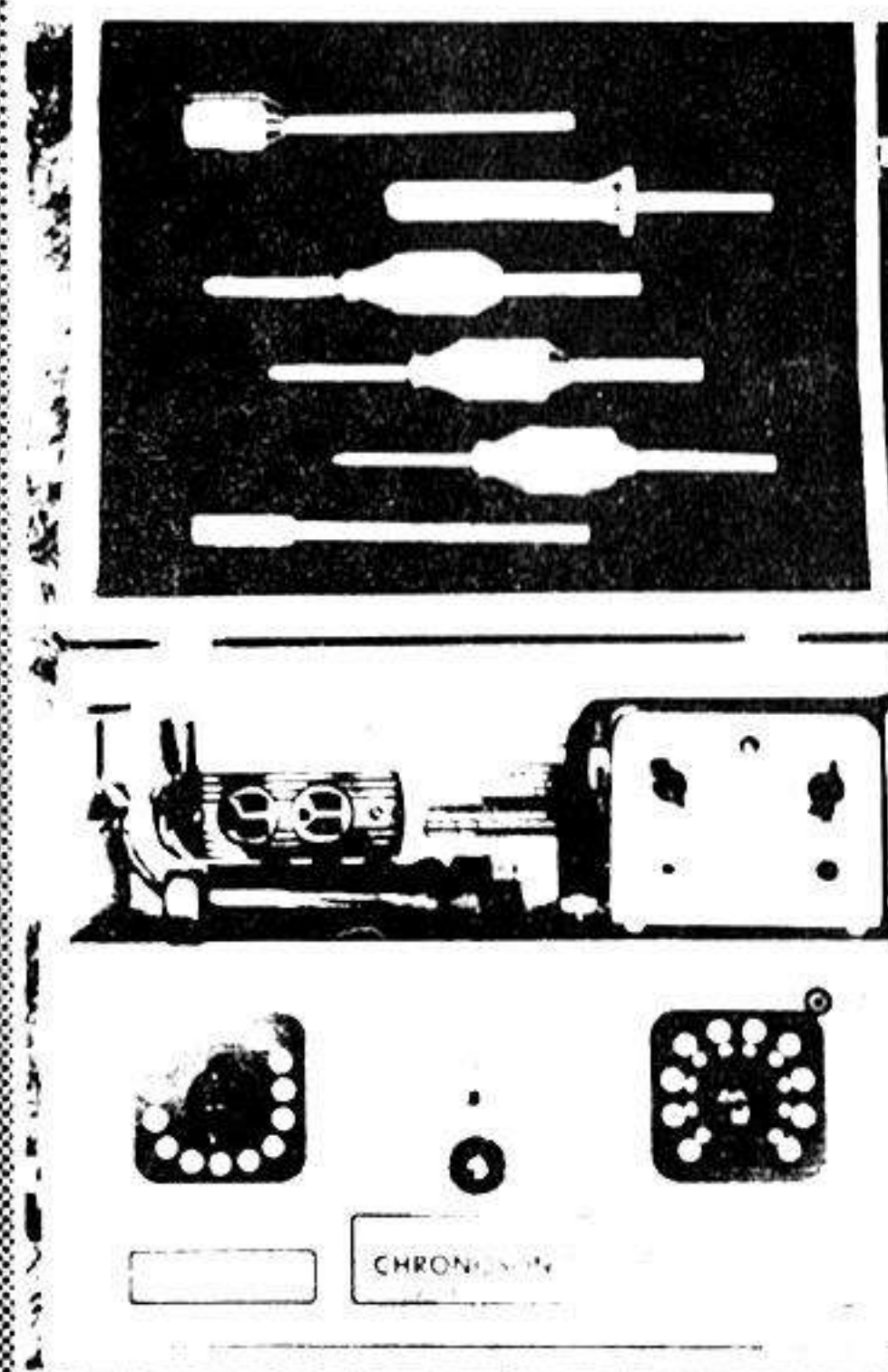
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- 3rd Session - 12 hours
The Neuro-Muscular-Skeletal Factors in Disease
- 4th Session - 12 hours
Clinical Cardiology
- 5th Session - 12 hours
Cardiology and Peripheral Vascular Disorders
- 6th Session - 12 hours
Circulatory, including Lymphatic, Disorders
(Clinical considerations)
- 7th Session - 12 hours
Disorders of the Respiratory System - Lungs
- 8th Session - 12 hours
Disorders of the Respiratory System - The Upper Respiratory
Tract
- 9th Session - 12 hours
Clinical Considerations of Special Problems of the Cardio-
Vascular and Respiratory Systems, Examination
- 10th Session - 12 hours
Upper Digestive Tract and Gastric Disorders
- 11th Session - 12 hours
Clinical Enterology and Proctology
- 12th Session - 12 hours
Pancreatic and Hepatic Disorders
- 13th Session - 12 hours
Renal Disorders (Clinical considerations)
- 14th Session - 12 hours
Genito-Urinary Disorders

- 15th Session - 12 hours
Clinical Consideration of Special Problems of Gastro-Intestinal
and Genito-Urinary Systems, Examination
- 16th Session - 12 hours
Overview of Diversified Chiropractic Techniques
- 17th Session - 12 hours
Allergies and Dermatological Problems in Office Practice
- 18th Session - 12 hours
Diagnosis and Treatment of Eyes, Ear, Nose, and Throat
- 19th Session - 12 hours
Clinical Endocrinology
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Nutrition and Malnutrition
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Emergencies in Office Practice
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Clinical Considerations of Musculo-Skeletal Problems
- 30th Session - 12 hours
General Seminar and Examination



**MEMBERSHIP IN COUNCIL ON DIAGNOSIS
AND INTERNAL DISORDERS**

1. General Membership	Annual dues	\$15.00
2. Student Membership	Annual dues	5.00
3. Qualified Internist	Annual dues	20.00
4. Diplomate	Annual dues	25.00
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For "Qualified Internists" and "Diplomates" there are special fees for the examinations for each rise in status and special fees for Certificates.

All general members, Qualified Internists and Diplomates are expected to have a permanent "Membership Plaque" and each year a new year sticker is sent when dues are received by the Executive Secretary.



COUNCIL ON DIAGNOSIS AND INTERNAL DISORDERS
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MEMBERSHIP APPLICATION

I hereby apply for membership in the Council on Diagnosis and Internal Disorders (CDID) of the American Chiropractic Association:

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Name _____ Age _____

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Chiropractic College graduated from: _____

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This application is subject to approval by the Credentials Committee, and it is understood I shall be informed of acceptance. I am a member of ACA.

In becoming a member, I agree to abide by the Code of Ethics and By-Laws of the Council on Diagnosis and Internal Disorders.

My application fee of \$15.00 and first year's dues of \$15.00 are enclosed. APPLICATION FEE IS NOT REFUNDABLE. Dues will be refunded if application is not accepted.

Applicant's
Signature _____ Date _____

Check or Money Order must accompany this application, payable to:
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NOTICE

*Dr. Cynthia E. Preiss, L.A.C.C. Graduate School Dean
has scheduled a new Class in Diagnosis and Internal
Disorders on the Glendale campus, January 20-21,
1979. The prescribed Syllabus will be presented for
the Qualified Internists Examinations.*

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COUNCIL ON DIAGNOSIS AND INTERNAL DISORDERS
OF THE AMERICAN CHIROPRACTIC ASSOCIATION

THE CHIROPRACTIC FAMILY PHYSICIAN

JANUARY 1979

VOL. 1, NO. 2



Harold Heintz Payne

O.C.R., D.C., F.I.C.C.

1910 — 1975

First President Council on Diagnosis and Internal Disorders

"DYNAMICS of CORRECTION of ABNORMAL FUNCTION" TERRENCE J. BENNETT LECTURES

EDITED AND PUBLISHED

By

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Published - 1977

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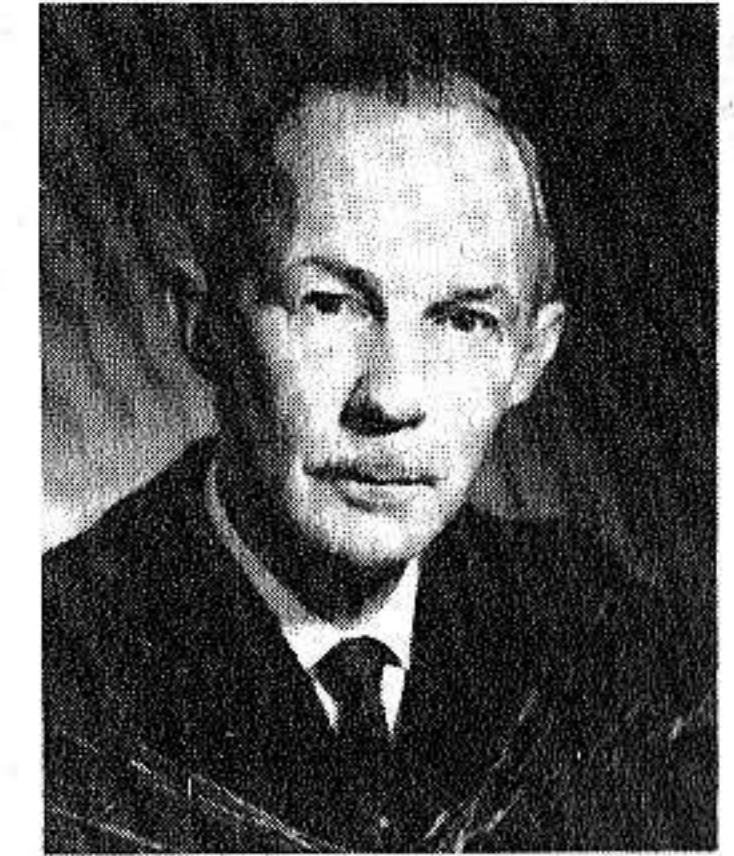
RALPH J. MARTIN, D.C.

TRIBUTE

Gracing our cover this issue is Harold Heintz Payne, D.C., F.I.C.C., O.C.R. Dr. Payne passed away in 1976 but the value of what he gave to the profession and the many students he influenced towards becoming **thinking** doctors capable of reasoning and evaluating what they saw will never end. Harold Payne was a scholar in every sense of the word with a consummate understanding of the subjects he taught as well. Differential Diagnosis took on a new clarity and meaning under the fine academic hand of this gentle man. As a man of great intellectual diversity, Dr. Payne was renowned for his scholarly grasp of history, medicine, music, photography and botany. He was a deeply spiritual man and this belief in God and Humanity was pervasive in everything he did. The measure of any man is not just what he did when he was alive but the value of what he left behind. If this is so, then by every measure Harold Heintz Payne was indeed a man of greatness.

CHIROPRACTIC CARE OF VISCERA JUSTIFIED

A. E. Homewood, D.C.



It is astounding to observe the embracing of the psychosomatic concepts by the practitioners of every school of generic medicine, but in the next breath the denial of the influence of the neural system upon viscera in health and disease.

Would that some authority provide an explanation of the mechanism by which the Psyche functions without the nervous system; or how the Psyche disturbs visceral function other than via the neural system; or how the hypertonicity in somatic muscle is produced by the Psyche, if not via the neural system.

From the beginning chiropractic has been ridiculed for emphasizing the neural influence upon every organ and structure in health or disease, while its practitioners proceeded to plod along getting sick people well, even in instances reversing the "irreversible" pathologies of the authorities.

D. D. Palmer taught that environmental irritation (stress), mechanical, chemical, and/or psychological, was responsible for structural aberrations that are called subluxations. The subluxation, a complex disturbance of osseous, myologic, vascular and lymphatic tissues, disturbs neural supply and serves to localize the adverse response of the body to the irritation. D. D. did not teach "pinched nerve" and "shutting off the flow of nerve impulses." Rather, he stated a number of times in varied words and contexts, "I wish that all chiropractors could take in this basic principle of our science — **that too much or not enough energy is disease.**" Nor was he unmindful of the twelve pairs of cranial nerves, the first two pairs of cervical nerves, the five pairs of sacral nerves, and the coccygeal pair which do not pass through typical intervertebral foramina, and cannot be pinched. He was aware that the disruptive influence of the subluxation was dependent upon a much more complex mechanism than direct mechanical pressure. Regretably, the naive, simplistic dogma of "pinched nerves" became rampant in the profession and a source of ridicule among the learned.

Regretfully, it would seem that the propaganda, not the facts, of allopathic medicine to which everyone is constantly subjected through every medium, has been able to do to chiropractic what allopathic medicine's best effort through legislation could not do — restrict the practice privileges to spinal or somatic conditions.

While much is written about chiropractors being Primary Health Care Providers, it would seem that the majority of practitioners are restricting themselves to somatic dysfunctions. Payment by third party providers tend to be restricted to the adjusting of subluxations and the diagnosis of the condition for which the patient was treated

may not be stated, but the attendant structural disrelation emphasized. This almost corresponds to the allopathic physician entering "streptomycin" or the name of the associated micro-organism as the diagnosis. Little has been done to convince insurance carriers and legislatures that chiropractic is, in fact, a distinct school of generic medicine and that allopathy has no inalienable right to diagnosis or the treatment of the sick.

An honest and objective answer must be sought to the question, "Does the public need an alternative health care system?" In truth, the only justification of chiropractic's existence is the fulfilling of a real need of the public. The answer to the question lies in the wealth of reports and books written by concerned allopaths, pharmacologists and knowledgeable laymen, which indicate that "deaths from doctor-caused disease in the magnitude of 200,000 a year" and "5 percent of the 28,000,000 hospital admissions per year are due to iatrogenic complications."¹

The plethora of available material would cause any relatively unbiased observer or investigator to provide an unequivocal "YES" to the above question. The public has a pressing need for and a fundamental right to an alternative to the risks of "unnecessary and irrational"² use of pharmaceuticals. Nor is this to renounce all and every recourse to the heroics of drugs with attendant risk. Better to have a patient with chronic drug reactions than one with rigor mortis. Nor is there any quarrel with conservative surgery when the physician has failed.

Since 1895 when D. D. Palmer first restored hearing, then normalized a heart problem as his second accomplishment, chiropractic physicians have established an enviable history of effectiveness which has remained the best kept secret of the century. From the success in the care of patients during the influenza pandemic following World War I through poliomyelitis epidemics, etc., the "old-timers" with their short course education and lack of knowledge that normalizing the nervous system by adjusting couldn't work, were continuing to practice, getting sick people well, but not advertising the fact from every roof top. Without reinforcement from their colleagues that such results were the usual and to be expected, many doctors of chiropractic assumed the attitude expressed by one of the present chiropractic leaders, " - - as a Chiropractic Orthopedist, I consider those good systemic responses incidental to adjusting for spinal pathology to be a welcome 'therapeutic fallout.' "³

This writer had the temerity to excerpt the principles from D. D. Palmer's extensive writings and then seek the neurological authority to justify or discredit those basic teachings of the founder and, also, obtain re-assurance for the application of chiropractic techniques in the care of visceral conditions. The result was the textbook, "The Neurodynamics of the Vertebral Subluxation," and justification for the results obtained in a practice with approximately 50 percent of the patients complaining of gastrointestinal problems. The diagnoses of the latter conditions were confirmed by a radiologist. Chiropractic results were most gratifying. This is not to suggest that adjunctive measures were not employed, nor that the mechanical, chemical, and/or psychological environmental stresses were not eliminated as much as possible, since that is a fundamental of D. D. Palmer's chiropractic.

The Neurodynamics of the Vertebral Subluxation seeks to clarify the neurological mechanisms by which those mechanical, chemical, and/or psychological environmental stresses produce subluxations, disturbance of neural function, the resultant aberrations of function, and tissue changes of disease.

Five hundred and sixty-three references are utilized to substantiate the thoughts expressed by the author. The following paragraphs are taken directly from the text with such modifications as may be necessary to clarify the subject when taken out of the context of the book, and sections deleted to shorten this article with the references noted.

VISCERAL REFLEXES

Exogenic irritants to any of the viscera can be traced to the spine and the most likely vertebral fixation prognosticated, thus permitting the doctor of chiropractic to conserve time and utilize applied psychology for the patient's benefit. Telling the patient beforehand in which area of the spine the subluxation is likely to be found and then proceeding to demonstrate its presence, is dramatic proof that the doctor knows his business and is a technique employed and advocated by D. D. Palmer.

Omission — 491

Any irritant introduced into a viscus, such as the lung or stomach, adequate to stimulate the receptor nerve endings, sends impulses back over the splanchnic afferent fibres to the spinal cord segments, as previously elucidated. Synaptic connection is effected with the anterior horn cells, resulting in somatic muscle hypertension, especially significant to the doctor of chiropractic, since postvertebral muscle fibres are involved. The degree and extent of muscle contraction is dependent upon many factors, such as the strength of the irritant, the local condition of irritability of the viscus, the state of irritability of the cells and synapses of the neuromeres, etc. This somatic muscle reaction to visceral irritation has received the descriptive name of "Visceromotor Reflex" from neurologists and "Motor Reaction" from Willard Carver⁴⁹².

That D. D. Palmer⁴⁹³ was cognizant of the importance of the visceromotor reflex as a causative factor in the production of vertebral fixations or subluxations is demonstrated by the following quotation, "Poisons taken into the system in food and water that is polluted or by breathing noxious effluvia from decaying vegetable or animal matter, or by the outrageous practice of the M.D. who injects vaccine poison into a healthy person, affects nerves, which act on muscles sufficient to displace vertebrae and impinge nerves, causing derangements which we name disease."

VISCERO-SENSORY REFLEXES

The Viscerosensory Reflex has received previous mention, but is deserving of repetition. As the sensory impulses arrive in the neuromere, they are transferred to second order neurons which, under normal conditions, subserve somatic structure. The resultant stimulation of an area of the postcentral gyrus causes a misinterpretation of the sources of the centripetal impulses and the conscious centre believe the pain to have originated in some somatic structure, rather than in a viscus.

Sachs⁴⁹⁴ has established that the Viscerosensory Reflex causes more extensive pain in the back than in the front, and Pottenger⁴⁹⁵ has demonstrated that disease conditions of the posterior portion of a lung tend to demonstrate somatic reflexes in the tissues of the back, while a similar involvement of the anterior portion of a lung has a somatic response in the anterior tissues.

While referred pain is one of the most important of the Viscerosensory Reflexes, hyperalgesia is a concomitant and is symptomatic, if not pathognomonic, of irritation

of a splanchnic structure. Therefore, the discussion of the neuromeres to which the afferent fibres from a given viscus return gives the required information as to the dermatomes which would experience the hypersensitivity of hyperalgesia. By eliciting cutaneous hyperalgesia, the doctor of chiropractic can be reasonably certain that he is faced with an organic problem, rather than one of somatic structure or a simple functional disorder of a viscus. In the instance that a patient consults him relative to "neuralgia" of the left arm, the history, causes of exacerbations, distribution of the pain, and vertebral fixations may all point to a diagnosis of angina pectoris, but the finding of hyperalgesia of the skin of the medial side of the arm and forearm would provide the additional confirmation necessary for such a diagnosis and justify instrumental investigation of the heart's function by means of cardiograms.

The mechanisms by which hyperalgesia is produced are not agreed upon by neurological authorities. Some feel, as Rasmussen⁴⁹⁶ and Pottenger⁴⁹⁷, that the visceral irritation lowers the synaptic resistance at the junction between the first order somatic afferent neurones from the skin and the second order neurones which conduct the impulses to the higher brain centres. Thus, minor cutaneous stimulation is sufficient to arouse unpleasant awareness. The muscles may experience a degree of hyperalgesia also, which Kuntz⁴⁹⁸ ascribes to the hypertonus resulting from the visceromotor reflex and states that the hypersensitivity persists as long as the hypertonicity.

Omission — References 499, 500, 501.

It must not be taken for granted that the visceral reflexes are the only method available for the viscus to inform the psychic centres of problems and irritations within its structure. As has been expressed by White and Smithwick⁵⁰², the viscera have the capacity of creating the sensation of pain localized in the organ itself, especially when inflammation lowers the resistance of the receptors. Wolff and Wolf⁵⁰³ bring out clearly the increased irritability of receptors in viscera by inflammation, as do many other investigators.

The viscerosensory reflexes, the hyperalgesia, and the visceromotor reflexes are all of very real significance to the chiropractor and he, of all practitioners of healing, should be acutely conscious of these manifestations of neural function.

Omission.

Prior to leaving the viscerosensory reflexes, it must be appreciated that the cutaneous distribution of the lower thoracic nerves is at a lower level than might be expected and, hence, the viscerosensory reflexes are not to be found at a level with the vertebra corresponding to the neuromere into which the afferents enter. As Pottenger⁵⁰⁴ and any standard anatomy text indicate, the tenth thoracic neuromere is concerned with the skin over the first lumbar vertebra posteriorly and the area which includes the umbilicus anteriorly, while the twelfth thoracic supplies the skin over the fourth lumbar vertebra posteriorly and just above the inguinal ligament anteriorly.

VISCERO-VISCERAL REFLEXES

Another extremely important reaction of the nervous system to visceral irritation and one of no small import to the skillful and learned doctor of chiropractic, is the Viscero-visceral Reflex which Pottenger⁵⁰⁵ credits with being the "basis of normal physiological integration." In disease, the viscerovisceral reflex may confound

diagnosticians and compound the problems of accurate diagnosis. Simply stated, irritation of one viscus may, through the connections made within the spinal cord and brain stem, disturb the nerve supply of another organ supplied by the same segment, resulting in symptoms from the second splanchnic structure which may be even more distressing than those from the viscus primarily involved.

One of the examples used by Kuntz⁵⁰⁶ is gastric distress in response to gall bladder irritation. In such an instance the afferent impulses would return from the gall bladder to thoracic segments six to eleven, and either by collateral fibres or internuncial neurones, establish a reflex arc with those lateral gray horn cells concerned with the sympathetic supply of the stomach from thoracic neuromeres six to nine. Increasing the sympathetic innervation of the stomach tends towards constriction of the vascular bed, increased tonus of the sphincters, cardiac and pyloric, and a general decrease in tonus of the muscular wall, inhibition of the secretory activity of the glands. Such a state may well result in the retention of ingested materials, faulty digestion, fermentation, flatulence, and other problems. These may be the symptoms which the patient presents to the doctor, rather than frank gall bladder symptoms. To treat the stomach would be a mistake, but adjusting the vertebral segments could create beneficial responses of the gall bladder, even though the diagnosis may be quite erroneous. The correct vertebral analysis and application of chiropractic technique often results in correction of problems, whose diagnostic name has been falsely chosen.

This same viscerovisceral reflex might well be applied in another manner. An atlas fixation may disturb the nerve supply to the gall bladder by way of the Vagus, upsetting its function. From the gall bladder afferent impulses may return to the thoracic neuromeres, as above listed, to disrupt the normal sympathetic supply of the stomach. It is self-evident that the atlas subluxation should be adjusted, but the visceromotor, viscerosensory reflexes and the hyperalgesia may make the thoracic problem stand out in apparent importance. Were the doctor to overlook the upper cervical disrelation, his patient might well experience considerable relief, but be afflicted with recurrences of this distress.

The reverse is well within the realm of possibility also. A thoracic fixation may upset splanchnic function and the afferents of the Vagus carry the impulses back to the medulla oblongata and through connector neurones stimulate the anterior horn cells of the upper cervical cord segments to result in hypertonicity of the occipital muscles and fixation or subluxation or disrelation of the attached segments, whichever term best suits the terminology of the reader. In such an instance, adjusting the upper cervical disrelation would not be to correct the primary problem, and the results might well be disappointing to both patient and doctor.

It must not be assumed that the viscerovisceral reflex is operative only between viscera whose neural cytones are contiguous. Such is not the case. The nausea and vomiting that may occur in the female with the uterine problem is an example, cited by Kuntz⁵⁰⁷, Pottenger⁵⁰⁸ and others. The afferent impulses from the uterus return to the lower thoracic, upper lumbar and sacral neuromeres and through connector neurones travel up the remainder of the cord and into the medulla oblongata to activate the vomiting centre in the reticular formation. Such reflexes are not the exception, but, rather, form the basis for the symptom complexes presented in most, if not all, disease conditions.

To Be Continued in March, 1979

"IS IT TIME FOR A SEPARATION?"

Richard H. Tyler, D.C.

Before entering chiropractic I was impressed with the many brochures published by the profession extolling the glories of what I wanted to be. The art work alone was inspiring. Young men and women were depicted as steely eyed visionaries ready to accept the challenge and the successes virtually guaranteed if they just decided upon chiropractic as a career. This all makes sense. The profession was trying to sell itself. What has never made sense to me, however, is the fear that seems to be in the very fabric of our being. No sooner did I place my feet inside the door of a chiropractic college as a committed student than I was assaulted with the concept that we had to continually fight for survival. Gone was all the inspiring rhetoric of the golden future I was to have in the second largest and fastest growing of all the healing arts. In its place was the hand wringing, whining and whimpering about how we were about to dissolve as a separate healing art. In the years that I have been associated with chiropractic I believe I have heard just about every tragic story about our imminent demise that could be spoken or written. Believe me, you can't call yourself a real chiropractor until you've experienced a "survival rally". It was explained to me that survival rallies were "necessary" every so often to "scare the daylights out of everyone" so that needed funds could be obtained.

One of the most popular themes has always been the "divided we fall" bit. Why if we don't "marry" our straight brethren it's just a matter of time before we're devoured by the AMA. What garbage! I'm tired of hearing that pitch. In fact I'm so tired that I think I'll just put things in reverse. If we keep associating with some of the odd balls in the chiropractic profession we're liable to be considered quacks like they are. Why on earth should I want to be considered in the same category as the poor soul adjusting his patients with one hand while holding a copy of one of BJ's tomes in the other? I'm sick of the tired litany of what BJ said, as if his words were infallible. Are we to consider the works of BJ divinely inspired? If so, does this mean that something like "The Chiropractor's Adjuster" is a New Testament? Are we then to be doctors or priests? If some chiropractors want to pray over their patients that's up to them — but I'll be darned if I'll let these same people decide what I must think and how I must treat my patients. I believe in the use of every viable diagnostic tool available when examining my patients. If I take a pap smear and discern a possible carcinoma and then refer the patient for proper treatment it's a lot better than "analyzing" subluxations and adjusting the poor patient until the malignancy has metastasized and is in a terminal stage.

I want a separation. I don't want to be with anyone who will compromise the well being of my patients. Since the "holy" straights probably feel the same about me let's make it official. Let's have a property settlement. I'll take the diagnostic tools and as many modalities as I can lay my hands on, and the straights can do a jig over their patients for all I care. The only sad thing about the latter is that the narrow concepts of the straights could do great harm. Before all the pious moaning begins I must tell you that I think of myself as a better adjuster than most of the straights. In fact, I believe the best adjustments I have ever received have come at the hands of mixers. I believe in the maintenance of structural integrity for the maintenance of optimum health but I also believe in other things and they include the belief that chiropractic adjustments are not a panacea. That's right — I don't think an adjustment will dissolve a brain tumor. I know I spout heresy but I also don't think that an adjustment will cure a ruptured ovarian cyst, either. I suppose I could go on but the point is made. I won't compromise. To stay "married" and have the two major associations join together, as both often postulate, what would I have to give up to make the straights happy? Maybe I could only use galvanic current once a week or maybe I shouldn't be allowed to use a stethoscope — ever. Well, I won't give away a thing. In fact I'm greedy. I want more. I feel I've been well educated and I want to use everything that education gave me the knowledge to use. Togetherness is not the answer. I don't agree with the "straight" approach to chiropractic. The romance, if there ever was one, is over. I want my freedom.

The above editorial comment is the opinion of the writer alone. It does not necessarily represent the views of the American Chiropractic Association, the Council on Diagnosis and Internal Disorders, or any of its members.

YOU ARE A CHIROPRACTIC PHYSICIAN not spinal technician!

Physicians must be practical scholars who buy and read current books which will keep them abreast of the times. Modern science is moving at a breath-taking pace which makes it impossible for the physician to keep up unless he buys and reads the latest material in all the areas of his expertise and practice challenges.

This Journal will pursue a policy of reviewing books which are especially worthy of being in your library and frequently on your desk. Your reading habits are as important to your professional image and self improvement as the classroom hours you spent in graduate schools.

You will find it most worthwhile to buy and read the books that we review.

INTERPROFESSIONAL DIALOGUE

It was recently decided by your editorial board that an input on diagnosis in the form of a roundtable discussion with different members of the healing arts might prove of value. With this in mind, a meeting was held and the conversation taped in the latter part of 1978. The participants included:

Ronald M. Lawrence, B.S., M.D. — a prominent author and lecturer specializing in neurology.

J. G. Anderson, D.C. — instructor in clinical neurology for many years and former Dean of the Los Angeles College of Chiropractic.

Ralph J. Martin, D.C. — Certified Chiropractic Internist and former President of the Los Angeles College of Chiropractic, and Chairman of L.A.C.C. Board of Regents, 1972 to 1977.

Richard H. Tyler, D.C. — Board Qualified Chiropractic Orthopedist.

What follows is but a small portion of our recorded meeting. Due to its length and potential interest the "roundtable" will be continued over the next several issues. We hope to continue this series of conversations with other qualified individuals as a regular feature of the Chiropractic Family Physician.

Dr. Lawrence:

I think from what I've seen of the chiropractic, osteopathic and allopathic professions of the last quarter century . . . that although all three professions approach a basic pathological situation of today in the same manner, each of the professions makes an approach based upon their expertise for what they are seeking. However, I think that the approach of the osteopathic and chiropractic professions is more intense. Basically what happens here is that the average DC and DO takes the basic history in an allopathic fashion and does the approach of the physical examination in an allopathic fashion then add to it the structural evaluations that enhance the diagnosis.

Dr. Tyler:

I have to agree with you basically, but I think it even goes beyond that in that the allopathic profession is a real specialty. Their diagnosis is their particular specialty. In other words, the internist is going to spend a lot of time on laboratory tests and internal problems and so forth, while the neurologist is going to be interested in the use of EMGs and EEGs. Everybody more or less 'favors' their own diagnosis for their particular area of interest. Do you feel we are guilty of this in chiropractic?

Dr. Lawrence:

Oh definitely. I think that the chiropractic profession certainly does the basic diagnostic work of people schooled in their common approach, and nine times out of ten, they more or less leave it rather than go into other areas because perhaps of lack of basic tools that might be more available in other professions.

Dr. Tyler:

How valid do you think structural evaluations are in relationship to the problems presented?

Dr. Lawrence:

Well again, speaking of the chiropractor, I feel that it is fundamental to evaluate even visual problems because the structural problems will reflect this and if chiropractors are well aware of this . . . and I hope that they all are . . . that when they find there are structural aberrations that are of certain patterns, and so forth, they will look for additional problems that are the cause for it.

Dr. Martin:

I'd like to ask a question that may throw this discussion into a shambles, but in 40 years' experience I would say that, by and large, the chiropractor and, to quite an extent, the osteopath, are both dealing more with an abnormal function than they are with pathology.

Dr. Lawrence:

That's very good. What has happened with the allopathic medical approach is that it's been directed more toward pathology and has not had anything directed toward structural disorders or abnormal function. This has been an area that is lacking very much. However, today, the allopathic profession is geared toward thinking about it . . . structural and functional problems. More so, because these things have been highlighted . . . the general public has been dissatisfied with general medical care because of the fact that a lot of these structural and functional disorders have not been approached with what they consider to be a proper fashion. These disorders were considered, if they were not pathologic, not to exist.

Dr. Martin:

But they **do** exist.

Dr. Lawrence:

They do. And as time goes on we see more and more explanations for a lot of these functional problems. Be that as it may, the approach of the osteopathic-chiropractic professions has been more or less geared toward understanding these functional problems. A Japanese friend of mine has said, "Listen to what the patient says. Listen to what the patient's complaints are."

The question of functional versus organic is an important question and since studies have estimated that 80 percent of all complaints today . . . physical, mental, or otherwise . . . relate to a functional disorder, this has become an important consideration. Functional disorders cannot be pushed under the rug. They have to be dealt with. The allopathic medical profession, by its own confession, has not dealt with these problems to the degree that they should have been concerned.

Dr. Tyler:

This brings out one other point; laboratory diagnostic procedures only tells us whether there is pathology, and if so, to what extent. It does not tell us anything about function.

Dr. Martin:

Functional disorders that may lead to a possible pathological process have been neglected, so we have to concentrate more on function if we are going to be successful.

Dr. Lawrence:

So that is the beginning of preventive medicine?

Dr. Martin:

That is right.

Dr. Lawrence:

I fully agree that many conditions begin with a functional problem and goes on into an organic one. We use terminology like micro-trauma and so forth which means as you know, that there are often the precursors of more serious things, and these are where the functional disorders lie.

Dr. Tyler:

We often get lost in laboratory diagnosis because we think that if the laboratory does not show it, there is not anything wrong.

Dr. Martin:

You are right. And now of course we realize that the laboratory is always secondary. If it confirms what you are doing, fine, but if it goes against what you think, then you know you have to re-examine the whole procedure.

Dr. Tyler:

I did an article not long ago in which I implemented eleven different diagnostic approaches on one patient and attempted to correlate the results as well as I could into a working diagnosis. I used everything from hair analysis to standard blood work to iris diagnosis. I did not care what it was, the esoteric as well as the orthodox. An iridologist analyzed my photos of the iris without being aware of any other findings. He diagnosed that there was a pathology of the right lobe of the thyroid in the patient. I had run a PBI, T3 and a T4 with negative findings. The Thermograph, however, indicated that there was a malfunction of the right lobe of the thyroid indicated by the iris. This indicated to me that the 'acceptable' laboratory work, which I would have thought would be a cardinal tenet in making the diagnosis, was probably wrong . . . that there was a hyper-function of the left lobe of the thyroid and which would have given a false positive or negative reaction. It pointed out to me how little the laboratory work had told me in this particular instance. Laboratory work, as with any other diagnostic procedure is viable only when we correlate it with other factors.

Dr. Lawrence:

I am glad you used the word correlate. I think lab work in all fields of our work is secondary. I think **all** the physicians in all the areas would agree with that. We have to correlate it, that is the word, the key word.

Dr. Martin:

How important would you consider the case history? I have heard some say that they consider it the most important aspect of diagnosis.

Dr. Lawrence:

Oh, I think it is vitally important . . . if you do not have a good case history, you really are starting blind. It gives you the direction you need to go to work.

Dr. Martin:

But do you take into consideration the emotions as factors of the individual's problems? They will not discuss certain areas, either because they have partially forgotten it, do not think it important or because they just do not want to discuss it. Do you not find such reticence . . . ?

Continued Next Issue

CHIROPRACTIC PHYSIOLOGIC THERAPEUTICS

by
A. C. Johnson, D.C.

LOW BLOOD PRESSURE

Blood pressure depends upon five factors: Heart force, resistance, elasticity of the blood vessel walls, the amount of blood, and the viscosity of the blood.

Low pulse pressure indicates a weak heart muscle as found in dilatation of the heart and in the degenerate changes of the heart muscle that causes it to fail. These cases have but little reserve strength. The heart and body fatigue under slight exertion.

Normal Systolic — 110-140.

Normal Diastolic — 70-100.

Pulse Pressure — 35-50.

Systolic pressure below 100 in men and 90 in women should be regarded as pathologic.

In order to decrease the blood pressure, there must be a decrease in the resisting or in the propelling force, or both, or a decrease in the amount of fluid circulating in the vessels. Low blood pressure will be found in cases of cardiac dilatation, myocarditis, and fatty degeneration of the heart, because these conditions weaken the heart muscle, the propelling force of the circulation. Low blood pressure is found in aneurism of the aorta, atonic arteries, and degenerations of vascular system because they decrease the resisting force in the circulation. Conditions such as a hemorrhage, dysentery, and effusions into the serous cavities, and the cachexic diseases, lower the blood pressure because they decrease the amount of circulating fluid. Anemia causes low blood pressure. Autointoxication is another cause.

EXTREMELY LOW PRESSURES

The conditions giving the lowest readings are: Shock, collapse, internal hemorrhage, and toxic paralysis of the vasomotor center. This latter condition is very common in diphtheria. In most cases of low blood pressure there will be a condition of hypo-adrenia, adrenal-cortex insufficiency, and this must be taken into consideration in the treatment.

TEST

The blood pressure and pulse rate of these patients show normal findings in prone, supine or erect positions but the key finding is the failure of the heart rate to increase when a demand is played upon it.

The patient can be requested to hop on one foot ten times and again on the other foot ten times, making sure that he lifts his weight well off the floor with each hop. This exercise of lifting his own body weight twenty times is a good, simple, well used and approved test of the heart's response to

exercise since there should be an increase in the pulse rate of approximately forty beats, which should then subside to normal within two minutes. The failure of the heart as an organ to respond to a demand is basically the result of the fatigue problem since it is poor circulation that causes the problem in the first place.

TREATMENT

To raise the blood pressure, use a joined 1" x 2" pad on each carotid sinus. This pad may be held in firm contact, to avoid prickling, with the patient's neck during treatment or wrapped with a towel. The negative cord will have to be bifurcated to activate both 1" x 2" pads. The positive or indifferent pads are placed under each wrist. Any 3" x 3" pads will do, if a 4" x 6", or larger pad is used, both wrists are placed down firmly on the pad. (Caution: no metal on wrists such as watches, bracelets, etc.).

Apply negative galvanism to the carotid sinus, 2-3 milliamperes for seven minutes to 10 minutes. Treatments scheduled every other day followed by infrequent check-ups (monthly checking of blood pressure).

SPONDYLOTHERAPY

To accomplish both an increase in the number of blood cells and in the volume of the blood stream, apply sinusoidal stimulation alternately to the 10th thoracic vertebra to excite dilation, and then to the 2nd lumbar vertebra to cause constriction of the blood-making organs. We may still further enhance efficiency of our treatment by using concussion or sinusoidal stimulation over the 3rd, 4th, and 5th thoracic segments, which contain the centers of origin of the nerves which directly supply the blood-making organs, in addition to the above.

CONCUSSION

Rapid concussion strokes are applied by placing two fingers over the transverse processes and concussing with the other hand on the fingers. The use of a plexor and pleximeter is more efficient; however, apply 10 to 20 strokes per second for 30 seconds and then rest for 30 seconds. Continue this way for 5 to 10 minutes.

Sinusoidal stimulation is applied by placing a large wetted pad electrode to the sacrum and smaller interrupter handle electrode to the segment involved. Use enough milliamperage to get good stimulation. On 30 seconds, off 30 seconds, for 5 to 10 minutes.

The treatment of low blood pressure depends upon the cause. However, in any case, it consists of building up a good quality of blood and developing all of the functional powers of the body.

LIGHT THERAPY

General body radiation with the radiant light 10 minutes, front and back, followed by ultraviolet radiation, starting with 3 minutes to the upper part of the body, 3 minutes to the lower limbs, then 3 minutes to the back, and 3

minutes to the backs of the limbs; gradually increasing time to 7 minutes to each area, or 28 minutes in all. 50-inch distance.

HYDROTHERAPY

Alternating warm and cold showers are beneficial. Each case is a case unto itself and judgment must be exercised as to which patients to advise taking the hydrotherapy treatments.

Electric cabinet baths or vapor cabinet baths are beneficial if given only for a short time; the long bath is weakening to some extent.

EXERCISE

The one necessary point in low blood pressure to keep in mind is the necessity of developing increased strength. Nothing seems as beneficial for this as to take long walks. I do not know of any treatment or exercise which has the same definite effect as walking for developing a strong blood pressure. Start their walks at once, covering at least a mile the first day and increase this distance gradually until they are walking at least five miles a day. When they are able to do this, take their blood pressure again and you will find that there has been a steady improvement as they have gained endurance.

In addition to the walking they should take vigorous physical exercises every day, starting with light exercises at first and gradually increasing the number of movements until they can exercise vigorously for 10 to 15 minutes without producing soreness of the muscles afterwards. Always be sure that they breathe deeply, both inhaling and exhaling to the full capacity of the chest while they are taking these exercises. This will assist in toning up the functional activities of the body and assist in recovering strength at the same time that the blood pressure is coming back to normal.

HYPOADRENIA

Low blood pressure normally stimulates the adrenals in an effort to normalize blood pressure, but when for any reason the adrenals are unable to react, the blood pressure remains low. If the vasomotor center fails to maintain the tonicity of the arteries and arterioles, or if the heart is feeble from any cause, the blood pressure remains low. The adrenals have a distinct effect on the arterial tension and the speed of the heart, and, in the absence of organic heart disease, low blood pressure calls for a study of the adrenals and the nerves activating them.

TEST

The patient who is dizzy on change of position, especially on rising, the patient who can't get going in the morning, the patient who feels best as the day goes on then suddenly seems to collapse around 4:00 or 5:00 p.m. is an example of the hypoadrenia patient and this patient will have perhaps a normal blood pressure sitting or lying but when on assuming the upright position, there is a DROP in the SYSTOLIC pressure of as much as 40 mm. The usual amount of abnormal drop is about 10 to 15 mm but any DROP is ABNORMAL. The Splanchnic veins have no valves and as a result are

dependent on the autonomics of the nervous system for their function and the tone of the splanchnic nerve is under the control of the adrenal system. The tone of the blood vessels of the abdomen therefore is under the control of the splanchnic nerves and when the patient stands up from a lying or sitting position there should be a rise in the systolic blood pressure of 4-10 mm from the recumbent to the erect position. Adjustments — Adjusting of dorsal segments 9 to 11 is important.

ADRENALS

To Activate — (Electro-Therapy)

1. Short wave diathermy to adrenals.
2. Electro-spinal therapy to 5 to 10 dorsal to increase secretion.
3. Interrupted galvanism — place positive 3x5 pad electrode to the occiput and cervical region. The negative pad over the adrenal region on back, 20 interruptions per minute at 15 to 25 Ma. for 10 minutes to each adrenal. See Electro-spinal Therapy.

SINUSOIDALIZATION

Sinusoidalization of the 9th and 10th dorsal vertebrae will activate the adrenal glands.

To Activate the Pituitary

Through eyes — positive galvanism to eyes, negative to occiput, interrupted type for 5 minutes to tolerance. Use eye electrodes.

To Activate the Thyroid

Infrared to Thyroid Gland.

Endocrine Therapy

In this condition in the male, adrenal substance, thyroid substance, and spermin extract with calcium are indicated.

In the female, thyroid, ovarian and adrenal substance are indicated. There are many laboratories preparing these glandular formulas.

If the low blood pressure is due to anemia, treat accordingly. See "Anemia". Whole adrenal dessicated substance Cetex C. (Anabolic).

Vitamin Therapy

Deficiency of A in atrophy. Deficiency of B in hypertrophy. Deficiency of C reduced adrenalin production; lowered blood pressure; irregular heart action.

Mineral Therapy

Calcium-Sodium activates the adrenals. Also Potassium and Zinc.

Since the adrenals have been closely associated with STRESS it is only natural that stress when excessive can deplete them; avoid stress.

To Inhibit Adrenals.

1. Electro-spinal therapy to upper cervicals and sacrals.
2. Sinusoidal current, place a 2x2 pad just below and on posterior side of each knee, give 10 surges per minute, noticeable contractions for 5 minutes.

The Chiropractic FAMILY PHYSICIAN

E. A. Wilson, D.C.

Vice-President

Council on Diagnosis and Internal Disorders

This discussion is relative to the chiropractor in the role of a family doctor. As far as I know at this time there are no ACA sponsored courses or any course for that matter that pertains to this particular specialty. Naturally there are areas in this field that we cannot fulfill as a family doctor such as the mandatory inoculations, etc., but in this day of specialization, even the medical doctor is not expected to do all of the things that he once had to do. However, we can certainly get into the main stream of everyday health problems and carry our share of the load and function as capable physicians.

Until we have organized classes pertaining to a general practice, I feel that this Council will be the council of choice. There are numerous books from which additional help may be obtained such as "Office Diagnosis", "Emergency Treatment and Management", and for that matter the old Merck's Manual can be a lot of help. Even though such books as "Emergency Treatment and Management" usually give you a medical way of handling a case, it is generally a quite simple matter to replace this with your own methods of caring for the same condition.

For the most part, emergency treatment consists of either inhibition or stimulation and you have drugless methods for these available to you in the form of some modality or manual technic as well as your own basic knowledge of first aid procedures. Those of you who can avail yourselves of the training this Council has to offer through accredited colleges, should do so by all means, for diagnosis will be the first step toward any of the specialties for which you may have aspirations.

In my own case, before moving to the country from Kansas City, I was fortunate to have worked with an Osteopathic Physician and Surgeon in a medical clinic for two years. I thought we had a pretty good thing going there, as I was giving spinal adjustments to ever so many of the clinic patients, who might probably have never been otherwise exposed to chiropractic. Unfortunately, his Board of Examiners finally told him that it was unethical for a D.O. to be associated with a D.C., that is in the same office, or for that matter an M.D. This was several years ago and I hope things have changed by now. (Down here in the boon-docks the world could go by and I would never know it.) Well, when I found out that this association had to be terminated, naturally I had to move out. I learned a great deal from this experience however, especially in the field of examinations, laboratory work and diagnosis, but I believe that the best thing that happened to me during this time was a new confidence regarding chiropractic.

How many of you reading this article now can honestly say, I mean honestly, that at some time or other you did not have doubts about adjusting, especially in a serious condition, or perhaps misgivings about your own methods as compared to what you thought the medical practitioner had, or maybe you just had a little feeling of inferiority at times when you saw them in their large hospitals and all the glamour and mystery that goes along with it. Have you ever gone through any of this? I have, numerous times in years past, but not any more. That two years in the clinic showed me without any doubt the fallacy of medicine. I grant you the mystery is there, but the fallacy is, too. This is not meant to imply that all medicine is bad. I do not mean this at all, but there are those times in which medication seems to be the treatment of choice, but these times are in the minority, and as we improve our own therapy and improve our methods, these times will become more and more in the minority.

Fear is holding us back . . . afraid that we cannot handle it. That's right, fear. We walk into a serious condition and doubts begin to hit us from all directions. Becoming proficient in the ways and means of a drugless type of practice is one way to overcome all of this fear. It is astounding what you can get accomplished by the judicious use of heat, light, water and other drugless methods. Naturally, this goes along with your spinal adjustments . . . this must be a part of your treatment. When a patient is sick you have to adjust them. But in order to apply your drugless methods, it is very necessary to make a proper examination, and diagnosis.

Once this has been done the battle is more than half over.

Now I am not a professional instructor or public speaker. I am just someone like you, competing with a well established and entrenched medical establishment. I thought perhaps that due to my location and circumstances regarding my own town that I may see more of a variety of cases than those usually encountered in a metropolitan area. I would just like to share some of my experiences with you.

I am located in a small country town, a farming community. There are two M.D.'s here. One of them is of questionable ability; the other one is a semi-retired M.D. and he puts a chiropractor in the same category as a cockroach, but the feeling is mutual. There are times when I am the only doctor in town. Believe me, this can pose problems. When I first moved here I was told that I would not last a year because of this semi-retired medical doctor. That was fourteen years ago and I am still here. It seems that a D.C. has always had a hard time in this town and as a matter of fact there was a chiropractor here when I came here and he was in the process of moving back to Kansas City. Well, I did not like this so I checked around and asked a lot of questions. I talked to merchants, the mayor and others and as near as I

could find out, those chiropractors before me analyzed the spine only, nothing else. Now I am not saying this is wrong . . . far from it, but it is a fact that they were unable to cope with this community by conducting such a strict practice. The man who was leaving here would not even do a chest X-ray. That is how strict my predecessors had conducted their practices. Well, I was here; I had to stay for I was broke. I had wanted to get out of the city inasmuch as my wife's folks lived here at that time, but they are deceased now. That was why I chose this town. While there was a D.C. here, I felt that there was room here for both of us. I did not know that he was getting ready to move away. So here I was in a town that never had really supported a D.C. That was many years ago and I developed a general practice as a matter of survival. It was either do that or follow in the same footsteps as the others who had not been able to make a go of it.

Today I have two CAs working for me and I do use numerous modalities such as short wave, ultrasound, sine and galvanic, hydrocolator pads, nutritional supplements, etc. I would like to mention some of the ways that I personally use vitamin therapy. It can be used much in the same way as an M.D. uses his drugs. B⁶ for example for a diuretic; vitamin A as a mucous repellent and expectorant; I'm sure you are all aware of these, but a bit of repetition will not hurt any of us. I am mentioning some of these things to show that it will be necessary to incorporate other methods, than adjusting only, into your treatment plans if you are to conduct a general practice and to function as a family doctor. If you are to remain a spinal technician, you are wasting your time reading what I have to say. But there will be those patients who will come into your office who do not need a spinal adjustment or would not permit you to give it even if they did need it, but they will respond to a proper modality. I will mention a case at this point to illustrate what I mean.

I have a female patient who recently underwent extensive open-heart surgery. It was a touch and go case for about two weeks following the surgery, but she finally started coming out of it.

During this time she was in the hospital, before she was released, she developed pleurisy with a terrific pain in her side that radiated around to the spine and under the scapula, then around to the anterior rib cage. The doctors did not seem to really be concerned about it and they released her from the hospital with this pleurisy. The condition became progressively worse and she returned to the hospital for help. She was simply advised to wear it out as they did not want to give her any more medication for any reason. If they cannot give you a pill, then they are helpless. This lady could not lie down; she was in constant pain and it was impossible for her to take a deep breath and was having extreme difficulty breathing at all. She had had pleurisy twice before and each time had gone into pneumonia, so she was

frightened. Her husband brought her in to me with the hope that I could do something that would provide some measure of relief. All of this was taking place within a month after surgery, so a spinal adjustment was both impossible and inadvisable to even attempt. However by having her sit upon a stool, allowing her to rest against a flat treatment table, propped up with pillows, she was able to get very comfortable. I was able to use short wave diathermy through the area of pain. I gave her three consecutive treatments, 20 minutes each treatment. The first treatment gave her relief and the third eliminated the problem entirely. Now these things can be done and we as chiropractic physicians are the logical ones to do it.

However, perhaps I should mention a few points regarding my location so you will understand why I do some of the things I find necessary to do. I am 65 miles from a major hospital and 45 miles from a second-best hospital and 12 miles from a small hospital that is not much more than a band-aid station.

I do have the advantages of medical consultations but this is primarily for surgical referrals. I have splendid cooperation with these men. One of them is an orthopedic surgeon, one a gynecologist, another a general surgeon and a very competent cardiologist. The problem is these men are too far away for any immediate help, so once again it is up to the general practitioner to get something done at the time, and if necessary, refer later.

I make house calls . . . quite a few of them. Some of these calls are in the Missouri river bottom as well as the Blackwater river and the Lamine river. If any one has any experience with river bottoms, getting around in them, you know it can be quite a hassel at times, especially at night. You get into your car at night and get down in this big river bottom looking for a house in the middle of the night, you can rest assured you are alone. You are really alone! Nevertheless, the chiropractic physician can do the job if he will apply himself and work at it.

There was a time in my professional life that I would not have attempted to make some of these calls. I would have thought, "an M.D. should make this call", but when you get down to it and you have to do it, you find out that you can do it, and it was not really so bad after all. You may be using hot pads all night, or you may be giving enemas, but when you have a sick patient you have to do something. You may be adjusting someone every five minutes to keep them breathing, but you can do it. Chiropractic helps and that also is at a premium. Remember that only about one percent of D.C.'s are in the small rural areas such as we have here. For the most part those who could be reached for help are in large towns and for the most part are only spinal technicians. There are very few chiropractic internists and even very few who could be classed as general practitioners. If you have a really sick patient these men are not really much help to you.

Continued Next Issue

Eugene J. Kraemer, M.T., D.C.

Eugene J. Kraemer, M.T., D.C.

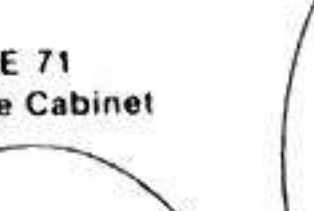
This case is presented because it is so typical of modern middle aged women in this country. She is a 58-year-old Caucasian female. Her three children are from 21 to 28 years of age and only one stays at home. This mother has been working for twelve years or more, her weight at the time of examination was 182 lbs., her height 5'0". She had pronounced edema in ankles and feet with considerable pain. Her pulse was 84 and blood pressure 152 over 92. She is continuing to work but reported that she does not feel at all good. When there is too much stress, either at work or at home, she becomes despondent. She has spontaneous petechial hemorrhages on the forearms and backs of hands, for the past year or more. During one two-month period she also had hemorrhages in first the right eye then a while after that cleared up the left eye hemorrhaged. A complete laboratory profile was performed a few days after the physical examination which showed evidence of a torpid liver and gall bladder congestion. The head of the pancreas also showed impaired function. For the sake of brevity, only abnormal findings of the laboratory report are shown:

There was a 16-hour fasting period before the tests.

Hemoglobin	15.2 gms.
Hematocrit	53.0%
Leukocytes (WBC)	12,770 per cmm
Lymphocytes	48. (n-33 to 38)
Glucose	68 mg/dl
Cholesterol	322 mg/dl
Sedimentation Rate	14mm 60 minutes (Norm 0-20 mm/hr.)

Due to symptoms of fatigue, despondency and lack of energy a glucose tolerance test was promptly done, with the following results:

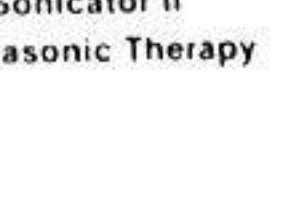
	Blood	Urine
Fasting	68 mg percent	Neg
½ hour	124 mg percent	Neg
1 hour	176 mg percent	Neg
2 hours	190 mg percent	Neg
3 hours	130 mg percent	ns
4 hours	78 mg percent	ns
5 hours	59 mg percent	ns
6 hours	73 mg percent	ns



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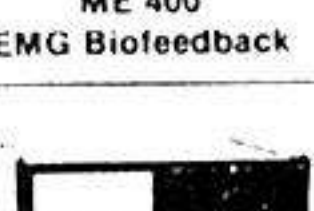
ME 200
Muscle Stimulator



ME 300
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Functional Thyroid Test (Barnes & Calton)

The under-arm temperatures consistently ran at 96 degrees or lower, indicating functional hypothyroid condition.

There was some question as to validity of the results reported, particularly the 15.2 Hemoglobin and Hematocrit 53. For this reason the patient was referred back to her medical physician for repeating some of the tests and for a prescription for thyroid and a strong diuretic. The results from the diuretic were satisfactory and clinically reduced the edema for the time, but the prescription thyroid did not seem to be any more effective than Thyrophin of Standard Process Laboratories.

After ten and a half months, BP was 135 over 88, weight 171 lbs., petechial hemorrhages on arms eliminated except for occasional slight reappearance.

There was definitely need for more progress, and improved laboratory facilities became available, and new laboratory profiles were done with the following results:

Sedimentation Rate — 24mm in 60 minutes (0-20 mm/hr.)	
WBC White Blood Cells — 6.300	Norm — 4.3 to 10.800
RBC Blood Cells — 5.33 per mil	Norm — 4.2 to 5.4 million
HGB — Blood Cells — 16.3 gms	Norm — 12 to 16 gms
HCT — Blood Cells — 47.9%	Norm — 37 to 47%
HDL/Cholesterol — 307 mg (100-225)	Norm — 100-225 mg
Serum HDL/Cholesterol	
Mg-DL — 48	Norm — Fem 55
Chol/HDL — 6.4	Norm — Fem 4.4*
*(Risk ischemic heart disease)	
Plasmaglucoase — 145 mg	(Norm less than 120)
T4 — 6.2 ug/DL	Norm — 5-12 ug/DL
T3 — 0.98	Norm — 0.88-1.13
Free T4 — 6.1	Norm — 5-12
Serology — Nonreactive	
Urinalysis — Negative	
Carbon dioxide — 33 meq.	Norm — 21 to 30 meq.
Triglycerides — 268 mg	Norm — 30 to 170 mg
LDH — 257 U/L	Norm — 100 to 225 U/L

Note: T3 and T4 are within normal (non-pathologic) laboratory limits, yet this case has every evidence of functional hypothyroid problems.

Current Diagnosis:

In this case we see a not unusual mixture of functional problems and pathologies. The pathologies are not hopeless, but they present serious challenges.

There may be some hope of working to retard the progress of the pathologies by working to improve the functional disturbances. Specifically, we want to reduce the carbon dioxide through a graduated daily exercise program. We wish to bring the metabolism up to normal functional level which will show an under-arm temperature of at least 98.2°. We expect to bring the weight down to below 140 lbs. This may be accomplished through exercise and diet, plus restoring her loss of endocrine balance. There appears to be periodic adrenal exhaustion characterized by depression and low levels of energy. In our physical examinations we find periodic evidence of sluggish liver function and at times gall bladder congestion. This is interpreted to be caused as much by stress of her life-style as from errors in diet. We are also mindful that this patient is a marginal diabetic and that diet indiscretions may play havoc with a wide range of physiological functions.

Conclusion:

This patient is receiving all the benefits of conservative chiropractic therapeutics ranging from spinal adjustments, vitamin and glandular food supplements, neurovascular checking, and treating of specific functional processes, physiotherapy and fairly close observation of her cooperation to change her life-style to conform to the requirements of her health problems. We expect to report again on this patient in a few months.

Continued in March 1979 Issue

BOOK REVIEW

THE NEURODYNAMICS OF THE VERTEBRAL SUBLUXATION

A. Earl Homewood, D.C.

249 26th Street North, St. Petersburg, FL 33713

Retail \$18. 20 percent off lots of 33; 33-1/3 off lots of 50 or more. Order from the author.

This scholarly contribution to the literature of chiropractic has run through three editions and this review pertains to the third which was copyrighted in 1977. It contains numerous updating changes, and is a challenge to chiropractic practitioners and students alike. It should be read carefully to examine their own views under the author's mental microscope and re-evaluate the concepts by which they have practiced or have perhaps lacked in perspective what they have considered chiropractic to be.

Dr. Homewood deals with a sharp scalpel with antiquated ideas which have interfered with the acceptance of chiropractic by the scientific community and demands that the ruthless light of science must reveal the foundations upon which chiropractic must proceed in the future. The author's scorn of dogma is implicit, even though skillfully sheathed in academic and scientific gloves. Dr. Homewood is a loyal disciple of the founder, D.D. Palmer, and defends the scientifically sound premises throughout the entire treatise. He agrees fully that subluxations have mechanical, chemical and mental causes with variable responses in each individual. He goes into extensive detail to trace the anatomical, physiological and neurological pathways which lead from initial stimulus to eventual subluxation.

In his chapter on The Basic Architecture of the Nervous System he clearly reveals the nervous system as a dynamic communication system plus a system of dynamics of almost infinite power to initiate and restore health. For those whose belief and faith in chiropractic is weak, Dr. Homewood shows clearly that for one who will take the time and effort to carefully examine the scientific facts, there can only be the strongest possible assurance that chiropractic is impregnable, and on a scientific basis it can never be refuted. The effects of the subluxation which are outlined should be reviewed from time to time for each time these are re-examined something new will come clearly to one's attention.

In the section dealing with the detrimental effects of cervical subluxations, the responses of thoracic neuromeres, the lumbar fixations and the sacral distortions the author reviews the basic problems found in daily practice. He sharpens the reader's appreciation of the indisputable realities with which he deals and the tremendous contributions which he is empowered by his knowledge to make toward the health of mankind.

Dr. Homewood brings the reader back again to D.D. Palmer's basic premises that the functional integrity of the viscus and of the spinal nerves are inexorable linked together and that the chiropractor must expand his horizons to treat all systems of the body and not contract to a limited musculoskeletal spinal specialist. He must always relate the nervous system to all the systems of the body.

— Ralph J. Martin, D.C.

Recently on a TV commercial a very large American corporation stated that they were dedicated to developing and producing the products and services that people need. This Journal is dedicated to promoting the concept that Chiropractic Physicians should provide all the essential health services that are not obtainable in the medical health systems. This covers a pretty wide range for our services.

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ANNOUNCEMENT

The Council on Diagnosis and Internal Disorders
Approves

A New Class leading to Examinations for 'Qualified Internist' at the
Graduate School of The Los Angeles College of Chiropractic, 920 E.
Broadway, Glendale, CA, starting January 20-21, 1979:

(Enrollment Limited)

Saturday, January 20 — 2:00 to 8:00 P.M.

Sunday, January 21 — 9:00 A.M. to 4:00 P.M.

This Council accepts candidates for 'Qualified Internist' or 'Diplomate Internist' examinations who have taken the required number of graduate hours of advanced clinical courses in an Accredited Chiropractic College. This Council does not engage in any educational activities outside the C.C.E. educational system.

This Council's position is that all graduates of undergraduate colleges require extensive special graduate clinical education to become Family Physicians.

We encourage all who are interested in practicing as Family Physicians with credentials as 'Qualified Internist' to organize groups of your colleagues and apply to the C.C.E. accredited college of your area to initiate such courses. Some colleges are conducting 'Residency' provisions for new graduates.

For Information Call: Dr. Cynthia Preiss, 240-7686 Ext. 22
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This Journal is discriminating in the advertising which we display. Vitamin products and food supplements which are not shipped interstate have no requirements to meet the standards of excellence which are claimed and their advertising will not be accepted. Family Physicians will require a much wider inventory of supplements than those who are engaged in a narrow restricted practice.

Family Physicians also require a wider scope of physiotherapy modalities including ultrasound, diathermy in various forms, sine and galvanic, orificial ultraviolet, various lamps, vibrators, belts, sleeves, neck supports, etc.

Since a great many family physicians' use of X-ray calls for immediate emergency diagnosis, it is a great advantage to have X-ray facilities in his own office. This expands the X-ray market for providers of such equipment.

The chiropractic family physician is a responsible member of the national team of Health Professionals and must be well equipped with modalities and inventories to provide a wide range of services.

COUNCIL ON DIAGNOSIS AND INTERNAL DISORDERS
OF THE AMERICAN CHIROPRACTIC ASSOCIATION

THE CHIROPRACTIC FAMILY PHYSICIAN

MARCH 1979

VOL. 1, NO. 3



George H. Haynes
B.A., M.A., D.C.

"DYNAMICS of CORRECTION of ABNORMAL FUNCTION" TERRENCE J. BENNETT LECTURES

EDITED AND PUBLISHED

By

Ralph J. Martin, D.C.

Published - 1977

- An Attractive Hardback
- Dark Blue, Gold Letters
- Numerous Charts
- Subject headings listed for each chapter

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L.A.C.C. Graduate School Announcement

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A TRIBUTE TO GEORGE H. HAYNES, D.C.

Dr. George Haynes, president emeritus, Los Angeles College of Chiropractic, has both his BA and MS degrees in chemistry, in addition to his DC degree. He is affiliated with the American Chemical Society, the American Association for the Advancement of Science, the California Academy of Science, the Biochemical Division of ACS, the Southern California Chemical Society, the American Chiropractic Association, the California Chiropractic Association and the International College of Chiropractors. In addition to his many years of leadership at LACC, Dr. Haynes was also instrumental in the attainment of recognition of the Council on Chiropractic Education by the Department of Health, Education and Welfare. Dr. Haynes has been involved in several research projects and has had numerous papers published. His address is 7852 Glencoe Avenue, Huntington Beach, California 92647.

In the period of over a decade (1960 to 1972) that Dr. Haynes served as President of the Council on Chiropractic Education he gradually assumed much of the leadership and responsibilities which had been previously been carried by Dr. John J. Nugent. Since the office of Director of Education had become rather fluid after Dr. Nugent vacated that position, it was particularly necessary that a member of the profession should again provide the vision, the motivation, the initiative and the energy toward our accreditation goals. Dr. Haynes supplied these qualities and pursued the contacts with Dr. John Fisher, the then Director of Education, which Dr. Nugent had developed in Washington. He prudently maintained steady pressure calling for the U.S. Department of Education to recognize our Committee on Accreditation as the accrediting agency for the chiropractic profession.

In 1972 Dr. Haynes declined re-election to the presidency of the Council on Chiropractic Education, but in doing so took on the responsibility of a special committee to push with the single purpose for recognition of our agency by Washington, D.C.

Soon afterwards the L.A.C.C. Board of Regents elected Dr. Haynes as President of the College and Dr. A. Earl Homewood as Dean. This gave Dr. Haynes more freedom from administrative responsibilities so he could devote his time and energy toward his efforts with the Department of Education in Washington. It was a hectic year in which Dr. Haynes was either in Chicago conferring with his committee or in Washington pressing for accreditation every month of the year. This involved frequent debates with AMS representatives before the U.S. Office of Education. On August 20, 1974 Dr. Haynes called me as Chairman of the Board of Regents and reported that he had just received a call from Washington that the U.S. Department of Education had granted recognition of our Commission on Accreditation as the accrediting agency of the chiropractic profession.

It is certainly proper that Dr. George H. Haynes be recognized as the dedicated leader and achiever who finally secured official educational recognition for our profession.

(Continued on page 11)

CHIROPRACTIC CARE OF VISCERA JUSTIFIED

A. E. Homewood, D.C.



(Continued from January issue)

SOMATO-VISCERAL REFLEXES

While the neurological authorities do not appear to have concerned themselves with the Somatovisceral Reflexes to an appreciable degree, these are the basis of the chiropractic contention that vertebral fixation or subluxation, if you prefer, create disturbed neural supply to splanchnic tissues. Much of this book has been devoted to discussion of such reflexes acting upon the viscera. Kuntz⁵⁰⁹ does mention the important influence stimulation of the skin has upon visceral function, especially the vascular supply and says, "... it must be apparent that many visceral disorders, particularly of the gastro-intestinal tract, may be influenced beneficially by appropriate stimulation of the corresponding cutaneous area." Pottenger⁵¹⁰ has pointed out that a continuous stream of somatic afferent impulses pass by connector fibres to neurones supply viscera and that these are essential for visceral function.

Sachs⁵¹¹ states, "The essential characteristic of visceral reflexes lies in the response of the internal organs to some mechanical irritation of the surface of the body."

Despite such recognition of the importance of these reflexes, little investigation seems to have been conducted to determine the influence of such mechanical irritations in health and disease.

PSYCHO-VISCERAL REFLEXES

One last type of reflex relative to splanchnic function that appears to be assuming greater significance in the present day literature of all the healing arts is the Psychovisceral Reflex. This mechanism is behind the psychosomatic problems, of which so much is presently being written. Cobb⁵¹² cites worry as being an accepted etiological factor in gastric hyperacidity and ulceration, as well as constant emotional strain resulting in arteriosclerosis. Kuntz⁵¹³ states, "Indeed, every visceral function is subject to influence exerted by psychic and emotional states through the autonomic nerves."

Omission. References — 514, 515, 516, 517, 518, 519.

Prior to leaving this phase of the topic, the writer would like to drop a word of caution to chiropractic students and practitioners not to become "caught up" in a popular trend, the psychosomatic "kick" of the present. While there has never been a question in the minds of doctors of chiropractic who have built their knowledge of chiropractic upon the foundation of D. D. Palmer's principles that the mind is an important contributory factor in the cause of disease, the somatic and visceral states

also have important predisposing influences upon the mind and the emotions. The human is a unit of structure and function; what disturbs structure, disturbs function; what disturbs the body, disturbs the mind; what disturbs the mind, disturbs the body. The human can be compartmentalized for purposes of discussion and description only, but never for purposes of function.

Experience and neurological facts should convince the chiropractor that the somato-psychic response of the body is of equal importance and stands upon a similar plane with the psycho-somatic reflexes. There is need on occasion for the application of mental catharsis as the first and major therapeutic agent. However, every mental problem has its reflection in the somatic structure and many are the instances when the problems of the soma are reflected into the psychic realm, making the somatic disturbance the primary source of trouble. Chiropractors should not underestimate the potency of their own technical armamentarium for normalizing structure as a means of reaching and eliminating the psychic dysfunctions.

The ever-advancing knowledge of the Reticular System into which all sources of afferent information are fed has shown that this system is responsible to a great degree for sleep, wakefulness, concentration, attracting attention, and influencing emotion. This gives further evidence of the inter-relation of body and mind.

Omission.

TROPHIC FUNCTION

Marcus Singer⁵²⁰ reported experiments that had been conducted to determine the influence of nerve fibres in the regeneration of body parts. It was found that the type of neurones present was unimportant, but the number was critical. It was presumed, although not proven, that the nerve fibres provide some chemical substance essential to growth. The sciatic nerve of a frog was implanted in the stump of its amputated foreleg and a new leg grew. Singer suggests that it is proper for the nervous system, which integrates and controls the thoughts and actions, to subserve tissue repair. Such a contention as the latter, has been held by chiropractors since the days of D. D. Palmer.

Not only is neural function important to growth and repair, but it plays an essential role in the functional aberrations and the cellular alterations of disease. There is a growing recognition of this important influence of the nervous system in the literature of the healing arts.

The trophic function of the nervous system is little understood at present, but is recognized as a proven fact. It has long been appreciated that, if the cells or the axones of motor neurones are destroyed, those muscle fibres associated in the composition of the Motor Units will undergo disintegration. This is not the atrophy of disease, but true dissolution with the loss of ability to be stimulated by any means and the loss of cellular integrity.

Studies in recent years since the advent of electron microscopy have demonstrated the neurotubules, and Minckler⁵²¹ credits these with the axoplasmic flow from trophic centre to the formation of vesicles in the terminal buttons of the fibres. It is hypothesized that the release of chemical substances influences the trophic activity.

Omission — References 522, 523, 524.

Feldenkrais⁵²⁵ mentions that habitual patterns of activity can modify both the bone structures in accord with Wolf's Law and the muscles, thus, the habit of faulty posture may result in fibrous deposits in articular cavities that have been exaggerated, shortening of some ligaments and muscles, while other muscles increase in strength and size, and others weaken and atrophy. These somatic responses are dependent upon the learning by the nervous system of a faulty postural habit.

Omission.

Feldenkrais⁵²⁶ has credited Miss P. Locatellis as having shown that the neural components are the "primary factor" concerned with the development of the tissues of the embryological segment. It would seem that the nervous system, even in the early developmental stages, is in command and remains as the correlating, integrating, and modifying factor that controls the responses of the body to the exteroceptive and interoceptive stimuli both in health and disease.

Omission — References 527, 528.

It should be obvious that the distortion of vertebral structure and the subsequent bombardment of afferent impulses cannot but have a disturbing influence upon the neurones of the associated neuromeres. Such alteration of neural integrity influences adversely the trophic activity of the effector cells and has a deleterious effect. These cells may demonstrate structural change or their resistance altered to make them more prone to the infliction of cellular trauma by such agents as micro-organisms, viruses and noxious chemical compounds.

* * * * *

It is hoped that the material in The Neurodynamics of the Vertebral Subluxation and the above excerpts strengthens the resolve of chiropractic students and chiropractic physicians to be Primary Health Care Providers in fact, not merely in name. There seems to be a wealth of facts to substantiate the claim that chiropractic care for viscera is justified.

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(Continued on page 19)

A CASE OF ATYPICAL, GENERALIZED, PALMAR/PLANTAR, CHRONIC PSORIASIS

by

Drs. Leonard D. Godwin and David K. MacMurray

Psoriasis (from Greek, *psora*, itch), a chronic, non-contagious, erythematous-
quamous eruption of unknown etiology, comprises in one of its various forms or
another approximately 4% of all dermatological conditions; hence, it is one of the
more commonly occurring skin affectations. Psoriasis is regarded as a "controllable
but not curable" disease entity which characteristically goes through several de-
velopmental stages until it settles into a relapsing, chronic phase with exacerbations
and remissions. It also has a decided tendency to a "selective localization," the most
common sites being the elbows, knees, anterior lower extremities, and the scalp.
The lesions of psoriasis are typically dry, thin, somewhat translucent, silver-
appearing scales which when gently removed exhibit the Auspitz Sign (small points
of bleeding). Psoriasis, along with Tertiary Syphilis, is one of a very few conditions
which may affect the palms of the hand and the soles of the feet, which when so
affected often produces weeping fissures.

In the latter part of 1976 a 54 year old, well-nourished, Mexican-American male
patient presented with the symptoms of an atypical, generalized, palmar/plantar,
chronic psoriasis which covered approximately 80% of his entire body, excluding his
head and face and neck and both forearms. Both his palms and soles were affected
with several deep, weeping painful fissures. His torso, front and back, was one
continuous, confluent raised welt of lesions. His condition has persisted approxi-
mately seven years prior to admission to our office, during which time he had spent a
small fortune on various medical treatments, even being treated at one period at the
Stanford Medical Facility, and also during which period of the succession of
therapies his condition had occasionally undergone mild, but not total, remissions.

Thorough orthopedic, neurological, physical and radiographic examination
yielded nothing of an exceptional nature in conjunction with his psoriasis. In fact, the
results of the various examinations indicated the same kind of musculo-skeletal
stresses so frequently seen in other patients, except that this patient claimed to have
had no particular problems associated with his spine.

The chief results of the X-ray findings are as follows: a 3 mm. functional short leg to
the left; a 7 mm sacral tilt on the left; a positive Shenton's Test on the left; a mild, left
lateral, functional S-curve scoliosis; splenomegaly as indicated by superior dis-
placement of the diaphragmatic shadow on the left; moderately enlarged bilateral
transverse processes of C-7; mild cardiac hypertrophy; segmented coccyx with the
coccyx sitting at a posteriorly increased angulation; a positive Ullman's Test for
spondylolisthesis (first degree); a Ferguson's Lumbosacral angle of 46 degrees; a
positive facet syndrome at L-5/S-1, but not reported as a symptom; the lower
lumbar spinous processes exhibited "kissing" approximations to each other; a mild
hypolordosis in the cervicals with a coronal stress line falling 8 mm. anterior to the
antero-superior aspect of C-7; C-5 presented a slightly wedge-shaped appearance

on the lateral projection (17 mm. on the posterior aspect of the vertebral body and 13
mm. on the anterior aspect; posterior slippage of C-5 over C-6 as indicated by a
"broken" George's Line.

The significant results from the other examinations are as follows: left blood
pressure of 105/83 and a right blood pressure of 105/82; the resting pulse rate was
72; the dual scales showed him to be 35 pounds heavier on his right side; he
exhibited a bilateral neurovascular compression syndrome (Thoracic Outlet Syn-
drome) as indicated by bilaterally positive Adson's, Costoclavicular and Hyperab-
duction Tests — not especially unusual in the presence of enlarged transverse
processes of C-7; reduction in the cervical lateral rotation was the only abnormal
ROM finding; he exhibited a dermatomic hyperesthesia on the right paravertebrally
and in both upper and lower extremities; he had a positive Weber's Lateralization on
the left; and exaggerated patella reflexes bilaterally.

The significant data from his Case History were: occasional headaches, right
hand tingling along the course of the Ulnar Nerve distribution, occasional vertigo,
three past incidents of head injured — one was a broken bottle over his head in a
fight.

This patient presented the picture of a demoralized, defeated, and dejected
personality, unemployed and out of funds. Dr. MacMurray, therefore, contracted with
the patient to treat him on an experimental, no-charge basis, requiring only that the
patient adhere religiously to this prescribed treatment schedule, which the patient
did. This patient received 42 treatments over an eleven week period and by the ninth
treatment at the end of the second week the fissures in the soles and palms of his
feet and hands were noticeably improved. Since all manner of treatments had been
previously essayed by medical doctors from megavitamin therapy to radiation, Dr.
MacMurray elected to confine his treatments exclusively to chiropractic manipula-
tive therapy of the affected spinal areas of malalignment as determined by Gonstad
markings on a Full Spine roentgenograph. Nothing else therapeutically was done
nor recommended.

At the end of three weeks of intensive, almost daily adjustments, or approximately
15 treatments, there was a clear reduction in the appearance of the psoriatic lesions
and the fissures of the soles and palms displayed obvious healing advancement.
From that time onward progress was rapid as normal skin seemed almost miracu-
lously to replace the formerly "angry" lesions.

By the time 32 chiropractic treatments had been administered, or about the end of
the seventh week, all lesions, including those of the soles and palms, had healed
90%. Ten more treatments and four weeks later, he appeared completely healed
and so was discharged. Over two years have now elapsed since that time, and the
patient has not experienced an exacerbation of his psoriatic state.

We are aware that this one instance does not constitute proof of much in a basic
scientific sense, but have elected to share this case with the profession because we
believe that many similar instances occur among chiropractors and never gain wide
circulation.

GROWING UP

by
Richard H. Tyler, D.C.

Not long ago I had the privilege of being invited to speak before a "practice improvement" seminar. The majority of those I spoke before were "straights". At one point I mentioned that I was a "mixer". There were some scattered boos, which was unfortunate but expected. I couldn't help but feel that I was at a revival meeting. Later, one of those attending the meeting engaged me in conversation. "I sure liked your talk," he said. I thanked him. "Yes," he continued "this has sure done me a lot of good. I was slipping and I needed this to get back on the right track."

How sad. How sad that he, or any of us, should "**need**" to be inspired or reminded of the value of what we do. That after a certain time the inspiration "wears off" and we feel the "need" to get the "spirit" again. A spiritual "fix", if you will. If we are properly educated in the physiology and mechanics of the body then the validity of what we do and its value to our patient's doesn't need these big circus camp town meetings. Most chiropractic journals are filled with advertisements from the technique peddlers and promoters of practice improvement "shows." Most of the ads are gaudy and cheaply exploitive. Search lights spotlight the slavish testimonials from those who just wouldn't have made it without Dr. "Larry". And you must return again and again for that good old time religion. That's embarrassing isn't it?

I get inspiration everyday from the patients I treat, when they tell me that they feel better, that they can hear or see better, that they can walk again or get a full nights sleep again. Who needs all that phony hoopla to tell us that what we're doing is right? I don't need any specially colored "bags" and I don't have to go to meetings with cutsey little names that are coined from the first letter of each word.

Unfortunately since the financial life blood of many chiropractic publications is drawn from the garrish advertisements that are placed in them and some of our schools get financial gifts from the seminar promoters it would seem obvious then that some moral compromises are made out of necessity. I also recognize that some in the chiropractic profession would never have succeeded in practice without the carnival atmosphere of some of the seminars. As I said at the beginning — however — the sad part is that any of us **need** this. Could it be that our schools don't prepare us for the outside world the way they should? Maybe a part of the curriculum should include a course in business management. And maybe some of the more greedy egotists in the technique world might be willing to give their procedures to our schools without charge. That's right **give** to the profession they claim to love so much.

Some day we'll be so professionally sophisticated that all the peddlers and pitch men will be a part of our struggling history. Until then I hope that most of you reading this will have enough confidence in yourselves as physicians that it's all history already. Until that time you might be interested in joining a new group I've formed called "CWAPAC". That stands for Chiropractors Who Are Proud and Confident.

The Chiropractic FAMILY PHYSICIAN

E. A. Wilson, D.C.
Vice-President

Council on Diagnosis and Internal Disorders

(continued from January issue)

Perhaps you would like to know what a cow-town doctor carries in his little black bag; especially if he is a chiropractor. Mine contains a sphygmomanometer, stethoscope, ophthalmoscope, otoscope, throat light, tongue depressors, cotton swabs, adhesive tape, gauze pads, bandages, iodine, merthiolate, burn ointment, burn spray, astringent such as VM120, two sizes of catheters, a colon tube, disposable examination gloves, rubber finger cots, activated charcoal capsules, vitamins C, A, E, niacin, B⁶, fever thermometer, instrument for splinter removal, wound clips and applicator. I also keep in my car a 30-minute supply of oxygen, and also in my office. I know there must be questions regarding catheters and colon tubes and wound clips as well as some of the vitamins I named. I will therefore try to relate some cases in which these things were used, then you will see it is not as far out as it might at first sound. I do not advocate that we all run around with a bag full of catheters and colon tubes. I would not do so myself if I were located in some other area, but I will advocate that each of you should know how and when to use these modalities, and that is all they are. There is not any difference in the proper use of a catheter than knowing the proper use of an ultrasound unit. There is no difference in emptying the urinary bladder and in emptying the colon when the patient's condition requires that it be done.

Article to be continued due to space shortage.

TRIBUTE TO GEORGE H. HAYNES

(Continued from page 4)

In another area of Dr. Haynes life and interests which is not so generally realized, I can let it be known that he was like a god-father to the Council on Diagnosis and Internal Disorders.

I counseled with him at every stony and thorny turn along the way of forming this Council and later in getting approval of our Syllabus for classes at L.A.C.C. In fact, he actually took our proposed syllabus and re-wrote it for us and presented it to the Council on Chiropractic Education and secured its approval. He has been available for counsel and advise and has lent his wisdom and energy toward every request that has been placed before him for the advancement and strengthening of the Council on Diagnosis and Internal Disorders.

On behalf of our Council, let us Salute Dr. George H. Haynes, the strongest and most steadfast friend we have ever had!

Ralph J. Martin, D.C.

UPDATE

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SHARE YOUR INTERESTING CASES

This Journal will feature a "Clinical Roundtable" in each issue. You are invited to share your interesting cases of puzzling ones with our readers and have comments from our consultants in various specialties in which expertise is required. You may either write up your cases or put them on tape as Dr. Wilson has done. Please type if submitting written manuscripts as hand written ones may not be easily read. Your interesting cases may help another doctor to realize that he may be able to provide care for a case that he otherwise would refer out to another doctor outside our ranks. Probably cases are being referred which are entirely within our scope of practice and perhaps with much less hazardous sequelae. Many D.C.'s may feel that their education or experience is not broad enough to engage in a family practice. The Council on Diagnosis and Internal Disorders hopes to stimulate interest in the profession in the Postgraduate courses which may be provided in the accredited colleges of the profession which will remedy such feelings of inadequacy.

In the alarming iatrogenic records which the medical profession has demonstrated, we owe it to the public to provide health services that are both safe and effective. We invite you to participate in recording what chiropractic family physicians are doing.

If this pricks your interest but you feel hesitant about how to go about it, write to Dr. William A. Nelson for the Dr. E. A. Wilson tapes. They are inspiring!

LETTERS TO THE EDITOR

February 26, 1979

Dear Sir:

I found the publication "The Chiropractic Family Physician" the best clinical journal I have read, especially the brief but thorough articles, made them enjoyable to read, and easy to digest. It is of great pleasure that I join the C.D.I.D. Keep up the good work.

Sincerely,

Bruce A. Moodie, D.C.



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INTERPROFESSIONAL DIALOGUE

(Continued from January, 1979)

It was recently decided by your editorial board that an input on diagnosis in the form of a roundtable discussion with different members of the healing arts might prove of value. With this in mind, a meeting was held and the conversation taped in the latter part of 1978. The participants included:

Ronald M. Lawrence, B.S., M.D. — a prominent author and lecturer specializing in neurology.

J. G. Anderson, D.C. — instructor in clinical neurology for many years and former Dean of the Los Angeles College of Chiropractic.

Ralph J. Martin, D.C. — Certified Chiropractic Internist and former President of the Los Angeles College of Chiropractic, and Chairman of L.A.C.C. Board of Regents, 1972 to 1977.

Richard H. Tyler, D.C. — Board Qualified Chiropractic Orthopedist.

What follows is but a small portion of our recorded meeting. Due to its length and potential interest the "roundtable" may be continued over the next several issues. We hope to continue this series of conversations with other qualified individuals as a regular feature of the Chiropractic Family Physician.

Dr. Martin:

But do you take into consideration the emotions as a factor of the individual's problems? They will not discuss certain areas, either because they have partially forgotten it, do not think it important or because they just do not want to discuss it. Do you not find such reticence?

Dr. Anderson:

Every patient has their own problems. You have to have a lot of skill to get a good case history. You must be a detective, a prosecuting attorney in a sense to get the information that you are looking for to get the picture.

Dr. Tyler:

I agree fully with that. The case history in my book is probably 75% of the work-up. Do you agree with that?

Dr. Anderson:

I do, because the case history tells you what you will be looking for in your examination. If you are making a work-up on a case, you have to have some objective. Without an objective, you have no place to go.

Dr. Lawrence:

The symptoms are not purely subjective to the patient. There is no sign that says "this is where you hurt." I have found that while I am interviewing a patient they will not impart all the information that I want so while I am giving the examination, I am also taking further facts for the case history.

Dr. Anderson:

It's all part of the process.

Dr. Lawrence:

Then things will come out that complete the picture.

Dr. Tyler:

That brings up a good point. Many doctors have said "I do not have time to take a good case history."

Dr. Anderson:

Yes, that is an important point that must be answered.

Dr. Lawrence:

You do a lot of it while you are making the physical examination. An interesting thing as Dr. Anderson said, so many patients have remarked after the examination "You have spent more time with me than any physician that I have ever seen." I have found in checking my time with the patient that I really had not spent any unusual amount of time with them. It may have been because of the interest. If you focus on the patient's problems with sincere concern to discover what lies at the root of their trouble, they are going to respond to your interest. You are quizzing them all the while you are making the physical examination. You benefit and the patient benefits. You benefit because you are saving time and the patient benefits because you are intent upon his problem.

Dr. Martin:

You hit on something there. A good rapport is part of the treatment.

Dr. Lawrence:

Yes, also a good diagnosis is part of the treatment. I think that most of us . . . let us forget for the moment that we are physicians or patients . . . like everyone else we have a fear of the unknown. Then when you know, when you get an understanding of what is going on . . . you feel better. When you, as a patient go out from an office, no matter how horrible the diagnosis may be, or how little it may contribute to the overall situation, you feel better when you know what the formerly unknown things really are about.

Dr. Tyler:

We were just talking about a patient that had been suffering from a specific pain for a couple of years and a diagnosis was developed that the patient had an alveolar cell carcinoma. The interesting thing was that his first reaction was "Well, then, thank God I'm not crazy." That just reinforces what we have been saying. Patients come to you many times fearing that the whole thing is mental. Many times it may be emotional . . . and there is nothing wrong with that. It is a valid area. This thing "It is all in your head" really makes me angry. It is important what the patient feels and what you feel, and none of it is that minor . . . that it is not important.

Dr. Martin:

That is what I was getting at . . . if the doctor establishes rapport with the patient and much of the patient's problem is emotional, right away he feels better because he feels "This fellow understands me."

Dr. Lawrence:

This is part of what we call catharsis . . . the patient has a chance to unload. Here is an example of this: I had a referral from a doctor, a Spanish speaking physician who sent the patient over for a neurological examination. As I talked to her she spoke with great feeling about her marital problems and I let her go on with it. She cried and with it all she had an emotional release. This probably was something that was valuable therapeutically. As we were taking the history she was crying and then when she left the office she said to me, "I feel so much better already." I only gave her a chance to unload. Physicians today . . . and by the way let me say the physician of old was a combination of not only a healer, but he was priest-like in his approach. I think that today where there has been a drifting away from the religious concepts and drifting away from the areas that might be dealt with in regard to a religious approach, we must return to those values and return to those things which have been lacking . . . to give spiritual solace as well as physical therapeutics.

Dr. Anderson:

Yes, I agree with that.

Dr. Lawrence:

A lot of people we see need this sort of thing.

Dr. Anderson:

What you are really saying refers to the present-day loss of faith. A lot of people have lost faith in medicine, but they have to have the feeling of faith in the physician they choose for it they do not have that, no matter what you do for them, they are not going to get well.

Dr. Martin:

We have to recognize that they have lost a lot of faith in religion itself.

Dr. Lawrence:

The physician, whatever his persuasion, can provide that necessary faith. He has to realize that within him he has that power to do this type of thing and he must reassert that power to do this. There is a tremendous loss of faith in the different professions. Let me ask you a question, Dr. Anderson: "As you have practiced over these many years, what are the differences that you have observed in the patient's approach to the chiropractic profession in the last twenty-five years?"

Dr. Anderson:

That is really hard to say. One thing that has always been the basic theme, and that is the identification of chiropractic with the spine. The spine is so well indoctrinated with the patients who come to chiropractors that is their primary concern that brings the majority of them to us, but I have noticed in the last few years there have been many other reasons than just spinal adjustments. Their experience has been that while they have come for spinal problems, other nice things have happened. Now they come for a wide variety of reasons. That is the greatest change that I have observed. They seem to recognize that chiropractic influences any number of functions in addition to spinal problems.

Dr. Lawrence:

That is interesting. In the medical profession in the last twenty-five years it seems there has been a drifting away with a great deal of concern with the medical-legal fears of being sued, concern for a proper diagnosis and proper care. In the medical profession there appears to be a rising suspicion of the physician. I do not know that I can say exactly what has been happening in the osteopathic profession but their being somewhat closer to the aopathic medical field probably have experienced some of that as an off-shoot.

What you say confirms what I feel, that there is a feeling that aopathic physicians have fallen short in their obligations.

Dr. Anderson:

It seems to me that the chiropractor is beginning to take the position of the old family physician. I know they come to me for a great variety of things whereas when I first went into practice they were practically all spinal problems.

(Continued in May issue)

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CHIROPRACTIC CARE OF VISCERA JUSTIFIED

(Continued from page 7)

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BOOK REVIEW

ESSENTIALS OF PHYSICAL DIAGNOSIS

Jay Davis Kirby, D.C., F.I.C.C.

I'm sure we can all remember the horrors of our board examinations. I was certain during most of them that they had me confused with someone else. Certainly I had never been taught about what they were asking questions on. Then, as though a shaft of sunlight pierced the clouds of despair, I recognized a question. Then two and three and more. I felt vindicated. I **knew** the answers. On several more tests the same thing happened. I began to realize that the subjects that I was surest in were those taught by Dr. Jay D. Kirby. He had always taught the subject he was assigned with great care. There was nothing cavalier or casual in his approach. He had a lesson plan that he had developed which would impart as much information as possible to the student within the time frame allowed. I had always come away from his classes feeling that I had been **taught**, and what was more — that I had **learned**.

When I was informed that Dr. Kirby had recently authored a text on diagnosis I eagerly procured a copy. I have many texts on diagnostic procedures but this one was by the man who had inspired my interest in research and diagnosis. Now my problem was to see if I could approach the volume without prejudice in either direction. If I could objectively evaluate what I was going to read.

Fortunately my job was done for me. The assessment could only be a positive one. The volume was so erudite and cleanly presented that it was almost as if I were sitting in one of Dr. Kirby's classes again. The text is 44 single sided spiral bound pages which makes it handy for notations. This is followed by a useful appendix and a simple examination form developed by Anna L. Reeves, D.C.

Beginning with the correct approach to history taking, the text develops a clear and detailed examination that touches on almost every aspect of objective diagnostic evaluation. I particularly appreciated the entire manual's obvious direction toward instructions to both the doctor and student in areas of ethical and legally appropriate thoroughness.

There are larger texts, more detailed and higher priced ones but none better. It pretends to be nothing than what it is — a detailed outline of the essentials of physical diagnosis. Everything from the interpretation of the appearance of the patient to the minimal legal X-ray views needed for specific situations is presented.

(Continued on page 25)

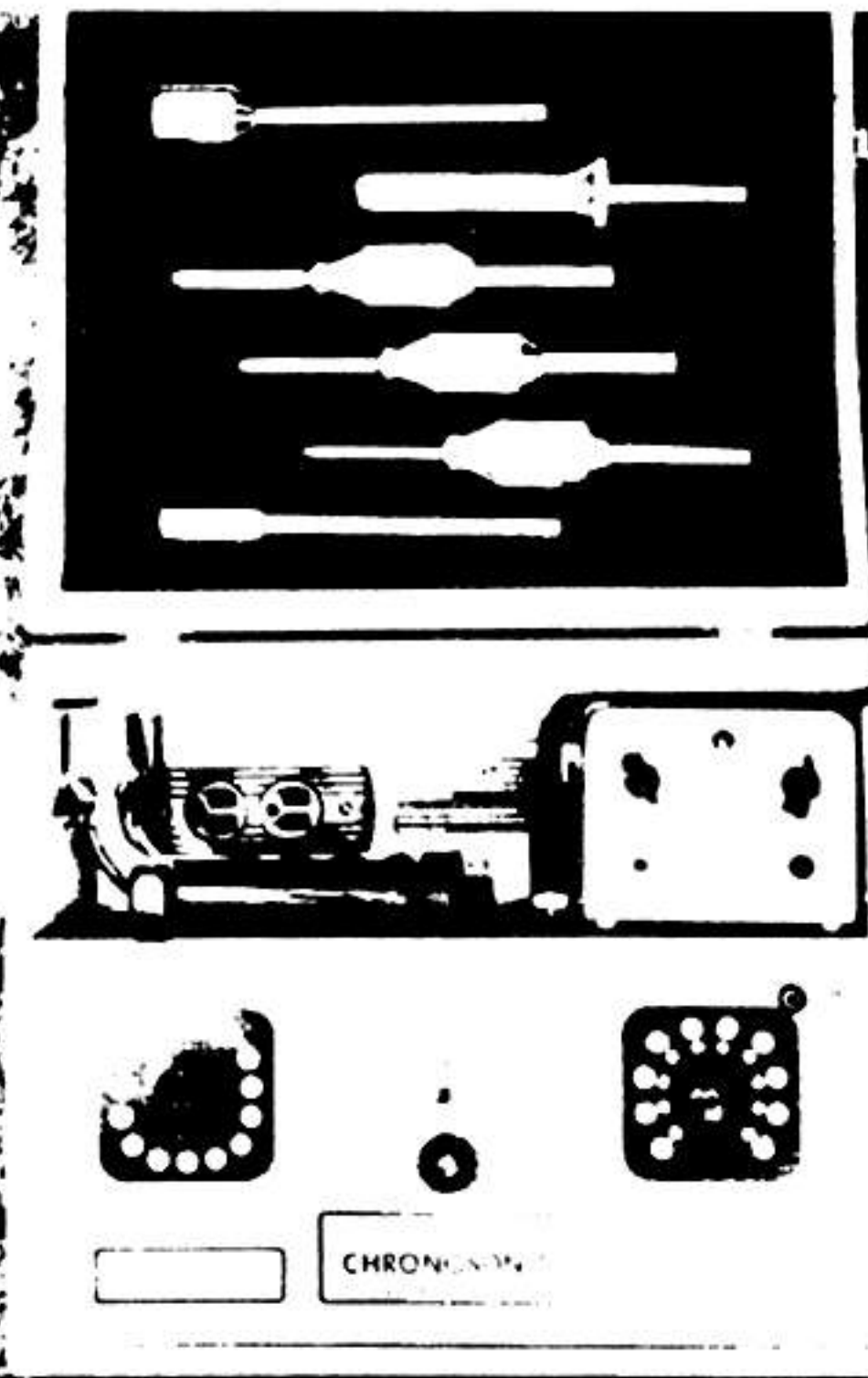
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CLINICAL ROUNDTABLE

Eugene L. Kraemer, M.T., D.C.

(Continued from January issue)

Case No. MM-2:

This case is an example of the use of the Laboratory in verifying a clinical diagnosis in our office. Mr. MM, age 54 years, came with a complaint that his ears were plugged and at the same time mentioned that he was very irritable. He was examined and the following findings noted:

1. Poor hearing in right ear.
2. Pain below right scapula.
3. Head of pancreas 3 plus by Bennett reflex examination.
4. Liver, lateral area 2 plus. At this point patient admitted to moderate to marked amounts of beer and hard liquor.
5. Right lung & bronchus 1 plus.
6. Prostate 1 plus.
7. BP 142 over 90.

We decided to instigate a laboratory panel and in addition we added lipase, prostatic acid phosphatase, an LDH isoenzyme and HAA (hepatitis associated antigen) for the benefit of a more complete diagnosis.

Laboratory results were as follows:

CBC 8 bands and a very slight increase in the MCH.

Sedimentation Rate 10mm per 60 min. — (norm, 0 to 10mm. per hour.)

Urinalysis — negative.

The following tests were abnormal and will be explained:

1. Creatinine — 1.6 mg. Norm. 0.7 to 1.4 mg. Increased in acute, chronic renal insufficiency, urinary obstruction, kidney disease.
2. Potassium — 6.9 meq. — Norm. 3.2 to 5.5 meq. Increased in renal insufficiency, Addison's disease, excess administration of potassium due to severe cell necrosis.
3. Uric acid — 11.4 mg percent — Norm 2.5 to 8.0 mg. Increased in gout, toxemia, polycythemia, leukemia, renal insufficiency, CVA disease, hypertension and pneumonia, (many other possibilities).
4. Triglycerides — 235 mg. Norm. 30 to 170 mg. Increased in Type 1 to 5, hyperbeta and hyperlipoproteinemia, also in hypothyroidism, diabetes mellitus, nephrotic syndrome, chronic alcoholism and fatty liver, biliary obstruction and stress.

5. SGOT — 50 units. (Norm. 1 to 40 units.) Increase in MI, hepatitis, cirrhosis, muscular dystrophy, biliary tract obstruction, opiates, antibiotics, calcium and shock.

6. SGPT — 67 units. (Norm. 1 to 53 units.) Increased in acute hepatitis and MI.

7. LDH — 252 units. (Norm. 100 to 225 units.) Increased in MI, myelogenous leukemia, acute hepatitis.

8. LDH-Is — Enzyme #5 = 21.0 (Norm 3 to 9.) Liver pathology.

Other tests such as amylase (acute alcoholism) LAP (liver), serum aldolase, ornithine-carbonyl transferase (alcoholism) serum cholinesterase, IV GTT, Lipoprotein-Phenotype and liver scan would be advisable at this time, but not essential, except for liver scan.

After examination of laboratory results, the following important data were noted:

1. Renal insufficiency, (creatinine, sodium, uric acid increased).
2. Hepatic conditions possible pathologic (SGO, SGP, LDH, LDH isoenzymes, and triglycerides increased.)

Working Diagnosis:

1. Possible renal insufficiency.
2. Possible liver pathology, due to excess intake of alcohol.
3. Pancreatic malfunction possible feed-back from finding in renal and portal systems.

Treatment Program:

Standard conservative chiropractic physiologic therapeutics.

Editor's note: These current cases are from the files of Dr. Ralph J. Martin in which he worked with Dr. Kraemer for laboratory aspects of diagnosis.

Members of the Council on Diagnosis and Internal Disorders are invited to participate in this Roundtable with cases in which Dr. Kraemer's expertise is available to make your laboratory test as productive as possible. Cases will be published Only with your specific permission.

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The chiropractic family physician is a responsible member of the national team of Health Professionals and must be well equipped with modalities and inventories to provide a wide range of services.

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BOOK REVIEW

(Continued from page 20)

We are entering increasingly demanding areas of health care. The modern chiropractic physician can no longer enjoy the luxury of palpation and X-ray analysis for his diagnosis. The chiropractor of today is a well-trained physician, skilled in the application of conservative therapeutics and skilled in diagnostic procedures. As primary physicians we must be superior diagnosticians and Dr. Kirby's text aids this concept. The volume is a "troubleshooter" — it's on my bookshelf and it should be on yours.

— Reviewed by Richard H. Tyler, D.C.

"CHIROPRACTIC PHYSIOLOGICAL THERAPEUTICS"

A. C. Johnson, D.C.
1539 N. Palm Canyon Drive
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This book is the most complete ever published, either in Physiotherapy or Chiropractic Therapeutics. It is indispensable for every chiropractic FAMILY PHYSICIAN. As a handy desk reference it is well organized, concise, indexed, and in every way a credit to the literature of the profession. Dr. Johnson has probably had a wider use of physiotherapy as a chiropractic modality than any other living physician. He says "For over fifty-one years I have worked for and practiced complete Chiropractic Physiological Therapeutics, treating the whole person according to the cause and diagnosis."

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Dr. Eugene J. Kraemer, M.T., D.C.

Dr. Kraemer graduated from George Washington High School in New York City, then attended Fremont College, School of Medicine and Los Angeles College of Chiropractic. He was licensed Medical Technologist, Cal. 1956. (#6362). Dr. Kraemer served as Laboratory Technologist, Cedars; Assistant Chief Technologist, Midway Hospital; Chief Technologist, Community Hospital, Gardena; Member, American College of Pathologists, Proficiency Testing; Member, American Association of College Professors; Partner for several years in the famous Knouf Laboratory; full professor at Los Angeles College of Chiropractic, 1977.

Dr. Kraemer was an instructor at L.A.C.C. in: Clinical Diagnosis, 1971-1977; Differential Diagnosis; E.E.N.T.; Dermatology and Syphilology; Laboratory Medicine, Clinical and Practical; Laboratory Director; Assistant Clinic Director.

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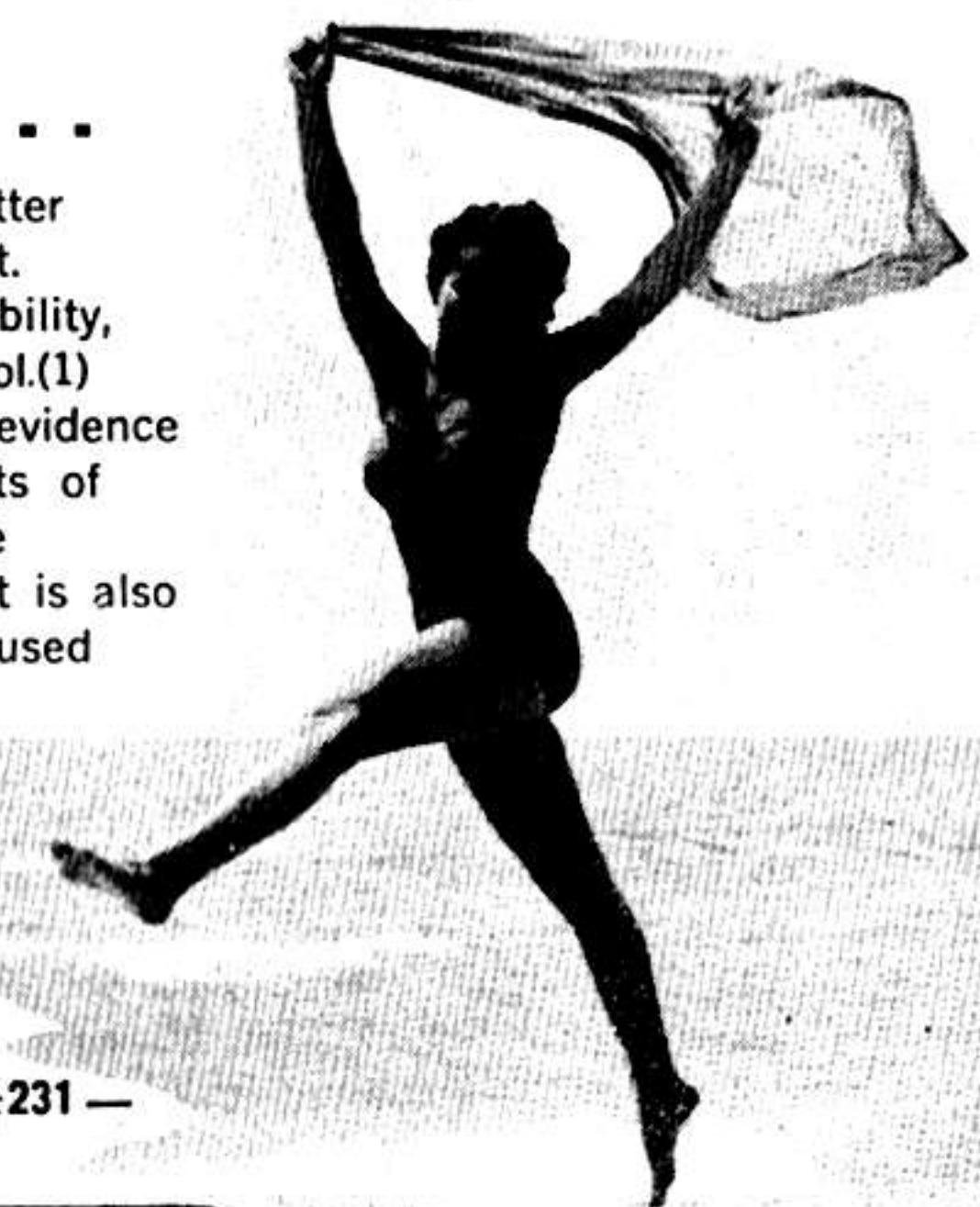
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ABOUT THE EDITOR . . .

Dr. Tyler is a graduate of the Los Angeles College of Chiropractic. Graduate Studies have included: Diversified and Reflex Technic, Therapeutic Hypnosis, and Chiropractic Orthopedics. Professional affiliations have been with The San Fernando Valley Chiropractic Society, The Los Angeles County Chiropractic Society, The California Chiropractic Association, The American Chiropractic Association, The ACA Council on Chiropractic Orthopedics and the American College of Chiropractic Orthopedists. Dr. Tyler is presently a staff consultant to the Pain Control Medical Group at the College View Hospital in Bel Air.

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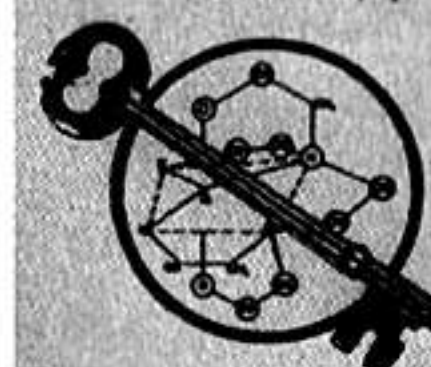
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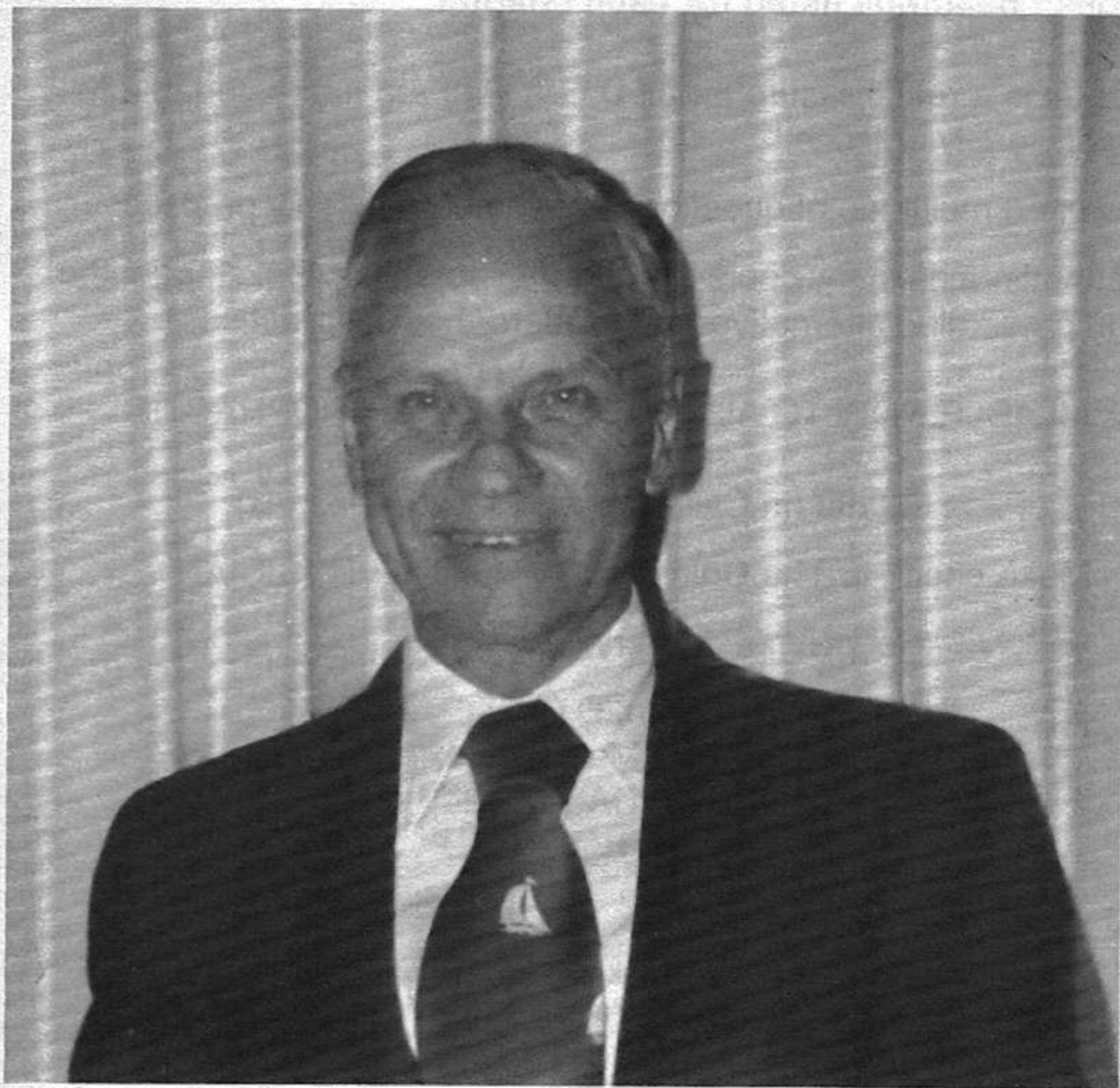
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VOL. 1, NO. 4



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SALUTE TO WILLIAM A. NELSON, D.C.

There are a few people in the world who see things that seem important to them and set themselves to the task of achieving their goals and stick to the job through all difficulties and adversities until success is realized. Such a person is Dr. William A. Nelson.

Back in the late 1960s he saw that there was a great need in the chiropractic profession to bring about a state of excellence in both diagnosis and clinical practice to secure our status as primary health providers in practical clinical fact which would demand public respect and approval, through high quality of general chiropractic services. With this goal in mind he joined with a few other like-minded colleagues to form the Council on Diagnosis and Internal Disorders of the American Chiropractic Association. This Council became a reality at the 1970 Convention in Hawaii. The new Board of Directors of the Council selected Dr. Nelson as Executive Director and he has carried that burden ever since, cheerfully steering through rough and troubled times and never complaining about the weight of his task. He has achieved his present status as Diplomate Internist, member of the Post-Graduate Faculty of the Los Angeles College of Chiropractic and Editor of the Chiropractic Internist along with many other honors with modesty and dignity.

Dr. Nelson is not only an outstanding figure in his profession but he is a dedicated family man with a lovely wife, Audre and three sons, two of whom are licensed, practicing Chiropractic Family Physicians.

In 1937 Dr. Nelson began his practice in San Francisco and is still located within a block or two from where he began. He is a concerned and patriotic citizen with the status of Coast Guard, Reserve Lieutenant, 1942 to 1945, also ship's medical officer.

Dr. Nelson's interest in sports has been consistent through the years. He is Past Commander, Flotilla 11, U.S. Coast Guard Auxiliary; 40 years and oldest member in the United States and still sails his boat about the Bay on weekends. Dr. Nelson is a member of Masonic Lodge, Sausalito Yacht Club, Past President of the Mission Optimist Club and many other social positions.

In Dr. William A. Nelson you see a man who is a well balanced person with many interesting and constructive facets to his personality. The Council on Diagnosis and Internal Disorders is fortunate to have such a man with his great capacities at its helm as Executive Director. He loves his work and is deeply dedicated to the objectives of this Council.

Ralph J. Martin, D.C.

THINKING BEFORE DIAGNOSING

by
Richard H. Tyler, D.C.

Several years ago I had a patient come to me complaining of severe pain on the right side of the lower thoracic/upper lumbar spine. She had been a patient of mine for quite some time but I had never seen her in such distress as she was on this day. The adjustments that I usually made in that region couldn't be performed due to the acute pain. I examined the abdominal area and found McBurney's point exceptionally sensitive. Something was radically wrong. Appendicitis was the first condition I thought of. "It's probably just gas," said my patient. "Why don't I just go home," she continued, "and call you in the morning." I hesitated. I had a full schedule of patients so such a plan would be easier on me. I looked at her for a long time. No, I decided to send her to the lab in the building for a CBC. I put a stat on the order and within the hour the report came back with an extremely high WBC count. I referred her immediately to the surgeon in the building. Soon he was on the phone asking me for the CBC differential. "I believe it's a hot appendix," he said. "I'd like to put her in the hospital right away." That evening my patient underwent surgery for appendicitis. The following morning the surgeon called me and told me that we both had made a misdiagnosis. "We found that she had a ruptured ovarian cyst and was bleeding to death internally. Had she gone home to call you in the morning, as she wanted, she undoubtedly would have died in her sleep."

I have told the preceding story on a number of occasions to illustrate the point that the lab work was important in diagnosing, or to put it more accurately *indicating*, that something was seriously wrong. To be sure, there are lab tests that are quite specific and correlated with a good physical workup can be very accurate. In spite of this, the AMA admits that just about half of the diagnoses made at the Mayo clinic and almost 80% at the doctor's office are incorrect.

Why have I gone into all of this? Simply because I was recently informed that a doctor, who read the last issue of CFP, became quite upset over that fact that I said that lab work wasn't any good. He then proceeded on some kind of an ego trip upon how valuable and specific lab work was in making the proper diagnosis. Now I don't mind it when someone disagrees with me. I'm used to that. However, if you don't agree with what I say, that's all right — just make sure it's what I *said*. The article in question was the roundtable discussion held at Dr. Ronald Lawrence's offices. Reference was made by me during the discussion about some apparently false negative lab tests I had ordered performed for thyroid function. I indicated that lab work wasn't a diagnostic panacea. Dr. Lawrence, a neurologist, agreed. Drs. Martin and Anderson, two well respected chiropractic physicians who were present, said nothing so I suppose one may presume that they weren't overcome emotionally by my rather obviously correct statement.

The importance of all this is that we all sometimes tend to jump to conclusions, which, if it concerns diagnosis, can be very dangerous to the patient. Some doctors are so eager to expound on something — on *anything* — that they speak just to hear themselves. For those in doubt — I believe in God, country, apple pie and lab diagnosis. If the irate doctor jumps to diagnostic conclusions the way he misinterprets what he reads — God help his patients.

THE CHIROPRACTIC FAMILY PHYSICIAN'S OBLIGATION TO HIS PATIENT

by
BERNARD JENSEN, D.C.

The Chiropractor has the ability to take care of the entire family in most cases, but in order to do this, he has to be qualified in many of the sciences that will take care of the body physically, mentally, dietetically, mechanically, and he must give the proper counseling. In addition the Chiropractor must have the proper knowledge to understand that if he does not have the ability to take care of that patient properly within the patient's needs, he should know that a referral is in order.

It has been said, not only in our own Chiropractic profession but in others as well, that all professions dealing in the Healing Art are too prone to become specialists going in one direction . . . having a skill that may often be masterful, and yet, is neglectful of *all* that is necessary to take care of the whole body.

There is much to be done for the physical body, but as we have grown in knowledge, and with work coming to us through mental and neuro-psychological fields, it is good that we recognize the tensions coming from many disorders that need to be cared for at the source.

At this particular time a revolution is going on in the Healing Arts in many different ways. Today there is a recognition that one cannot practice any one art and expect to take care of everyone in that one art. However, as we go through our training we find that very few doctors refer cases without seeing that the patient first goes through their particular program. I feel that many a patient has been neglected by not looking at the patient rather than the disease or the pathology expressed when coming to the office. Many doctors do not realize that 90 percent of the patient is on the other end of bursitis or in any skeletal problem. We find that nerve tensions perhaps can be taken care of with drugs, relaxants, and so forth, and then another man with acupuncture can do a very good job of relieving these tensions. Chiropractic is a masterful art in this respect, but we find that many times when a person has led a life bringing him to an extreme life of tension and expression which finally asserts itself in hyperacidity, hyperchlorhydria or some other pathology, we have to recognize that counseling is the next step. There is every possibility that a person who has led an extremely nervous and tension-filled life through perhaps a marriage, an occupation, money disasters, and so forth, these conditions result in many skeletal problems and need to be cared for.

In this day and age of scientific progress, which in itself has created so many of the foodless foods, we are not able to find a family physician. Life can begin right in the pantry and in the kitchen.

So little nutritional work has been taught in our colleges today. Doctors have become one-sided in their treatments and do not take in the dietetical arts which are so fundamental in that every cell structure in our body is made up of the dust of the earth transmuted to us through our vegetables, seeds, nuts, fruits and everything

that we eat from the kitchen. With this realization the Chiropractor has the greatest opportunity to become the family physician, and he probably has the greatest opportunity to give Nature the first opportunity in trying to see that a patient is put on the right track.

Nature knows best . . . nature is almighty . . . nature is all powerful, all expressive and all inclusive. As we have been trained, we must give Nature the opportunity of getting us well. We recognize that interference with the life force can come back and cause tension in the spine, backache problems, and reversal problems. Often this comes from the brain which is the incitor and motivating factor in much of our functions and problems within our body can be traced back to a mental disturbance, often unrecognized by the patient. As a Chiropractic Physician the cause is most important to locate.

I had the ideal at one time of bringing together six doctors on a counseling board including the top professional men as well as the Chiropractor, an Osteopath, an Iridologist, a man who used water cure treatments, one that works completely with Nature Cure, or any art that could be used in the hygienic care of the body, and have the patient go through this Clinical Counsel. If that condition could be handled by Nature first, and then under good counsel, good manipulation, and so forth, then I believe that this person has the privilege of seeking out and deciding which way to go. Perhaps many an operation could be avoided. It has been brought out through the Mayo Clinic years ago that over 9,000,000 unnecessary operations were performed on women for abdominal problems during a one year period. I feel certain that a number of these operations could have been prevented through the proper dietetic counseling, family counseling, mother counseling and kitchen counseling.

One of the biggest problems we have today is in making sure the patient is in the right doctor's hands. We do know there are many patients who are not inclined to go any other way but the medical and surgical way. The patient should have that privilege, but we should also have the education in order to disseminate the knowledge for those who would like to see another way. Many a patient today is lost in the shuffle of trying to find the proper doctor. Many a patient is a doctor-shopper today. Most of the patients that come into my office have tried this, have tried that, but without results. This is not the practice that should be going on with our doctor/patient humanitarian principles that are being worked out today.

I am convinced that most patients want to do the right thing, but do not know what to do! They don't know which doctor will be able to help them with their particular disturbance. Today many a patient would like to find a doctor that would set up a dietetic program. They would like to know where they can go to have counseling . . . where they can be educated as to what foods to prepare for their families . . . how to cook properly, how not to cook. It is not a matter of having a good cook in the home, but is instead having one that knows the natural art of healing as found in the proper nutrition as it should be expressed today. Throughout the United States today there are 40,000,000 patients on diets. Where did they get this information? They are getting it from lectures and most often from books written on diet. Most of them do not get this information from a doctor's office. This is an area where the Chiropractic Family Physician should take over and see that it is taken care of properly.

An education program should be set up for these people to study and learn the proper dietetic procedures for their own particular health and that of their families. It borders on the criminal for people to leave a hospital and not have the proper education to keep them from coming back again. Why is it said over and over again that one operation leads to another? Why should we make a living on sick uninformed people? It is time for them to have the privilege of good counseling and a good educational program.

I believe every Chiropractic Physician should have a weekly course of instruction on the happy, healthy way of living . . . starting right in the home. There is no reason why these people should not know there is a cleansing way of going, and also, to know there is a suppressive way of going. Then they have the privilege of choosing. The patient is one of free will and should be selecting you as the family doctor because you are the one furnishing something to keep them well, not only from a physical standpoint, and from an integration standpoint within the family. If we have real love for the patient, the patient has the freedom to select the doctor who is right for their needs. It is for the doctor to see that the patient has the proper information and material to work with. I am convinced that if a person is given the proper light, he will find his own way. Most people do not know which side of the body the liver is on. They do not realize that many a pain can be a reflex pain, and yet again, they are trying to diagnose themselves. They need straightening out. They should go to someone who can give them the proper interpretation of their problem and how they can correct it, or, guidance on the various means that are available to correct the problem or problems.

Certainly it is no crime to refer a patient to a rectal specialist, to an X-ray laboratory, or to a doctor who is more capable than you in specific areas. Master two or three of the sections within the healing art that you are known by and handle these areas well. I'm sure you will be able to help more patients if you are master of one art, but you should be well aware of all the ramifications that may be handled by the other arts which can go along with the masterful art that you know.

Every Chiropractor should recognize that our adjustments depend upon what kind of a body is going to hold that adjustment; what kind of a digestion exists in order to build a good bony structure, good intervertebral disc cartilage. We have to recognize that calcium is necessary when we have the proper adjustment . . . calcium is for knitting and we cannot do a good job in overcoming any pathology or any sickness in our body without the proper amount of calcium in the body. With Chiropractic adjustment alone we cannot handle the skin problems. Of course, many a skin problem can be caused from nerve tension, and Chiropractic can be the master art at this moment. But . . . when we have a shortage of the chemical element Silicon so necessary for that skin, there is no reason in the world that this tension should not be taken care of by both Chiropractic and Silicon and make the job complete. In this way the Chiropractor becomes the Family Physician.

If marriage problems are causing a disturbance within the stomach, and of course, we've heard many times that "you make me sick to my stomach," there is no reason in the world why we should not add to our nerve corrections through the spine the

proper nutrition that is going to feed that person until they have had an adjustment within themselves or within their environment which may be causing their problem. Money can often be the "root of all evil" . . . or at least the thinking of money problems, the losses, the mortgage, and so forth. Our health can be uprooted when there are money problems and disturbances. A good counseling treatment is in order. A health-giving philosophy should be taught. Often, however, we find we live on the beliefs of patients and if we are believing a lie then we live a lie. We have to see that people are considered in their beliefs. It is much better to be a happy Christian than a miserable one.

Most of the patients today have people problems. It is not always what is wrong with you, but who is wrong with you. The patient must develop a philosophy . . . they have to know themselves a little bit better . . . then they often find they understand others better. They have to learn how to go ahead unafraid, not expecting problems to dissolve, but learning how to handle problems with love and joy in their hearts. Many people are killing themselves looking for a Utopia. This is something they will never find, but are they going to be treated by a doctor all the time they are trying to find it?

When we stop and think about it, the most precious work to the Family Physician is taking care of the children, a new generation coming forth to progress and advance beyond what has gone before. But without the proper guidance, without the proper motivation and understanding, the children will be raised as doctor bills. Of course, diet and nutrition are very important in the growing years of the child. Each child should have the confidence in knowing that father and mother know best and that all is well as far as their health is concerned. How many tonsils have been taken out when the problem was due to dietetic errors, poor bowel management, and probably a lot of emotional disturbances at the table. Lymph gland congestions are taken care of beautifully from a mechanical means, but will they come back again? Are we living in the preventive medicine stage? . . . An age when we can go in and assume the responsibility of this educational void by being the family physician? We have to consider that preventive medicine is most important.

The Family Physician of the future must make the effort to see that all healing arts . . . mechanical, chemical, mental . . . get together. If we can build a practice based on the principle of keeping the family well . . . keeping them integrated as far as health is concerned . . . then we are going to have the family that is not only healthy, but is going to be a happy one and a blessing to everyone in their particular world.

Happiness leads to health. Health leads to happiness. A plan should be set up so that once a year your patient will come to see you, or, the family will come to see you as a unit and just see where the problems can be. Have we anyone in the family that is being neglected because they are a different type than another? Do they all have noodles and ice cream hoping that this diet will keep them well? Have we an overweight mother who likes certain foods and serves it to those who are built differently within the body? Sometimes it has to be clarified and understood by family members that some people have a stronger digestion than others, and those who do not, must have a little bit of extra care in respect to their nutrition . . . to their little

problem. Perhaps there is a hyperactive child. Is there any reason why the mother and the child should not be counseled in the principles of good nutrition in order to feed that child's nervous system which is constantly breaking down? Who is qualified for this new educational program? I truly believe it is the Chiropractic Family Physician. He has been trained in the natural healing arts and he recognizes that Nature does the healing.

Now is the time when we should assert ourselves and come out and give Nature that chance in the family.

POSITION PAPER of Council on Diagnosis and Internal Disorders

"This Council takes the position that the traditional and legitimate practice of chiropractic is directed particularly (but not exclusively) to the correction of all areas of abnormal physiology. In accomplishing this we must have wide latitude in diagnosis in order to differentiate abnormal physiology from irreversible pathology. The restoration and maintenance of normal function of all systems of the body is basic to the principles of chiropractic preventive therapeutics. We maintain that there can not be any division or restriction of the systems of the body; we must be free to work with all systems because restrictions to any one systems would prevent success with those not restricted, based on the generally accepted holistic inter-relationship of all systems of the body."

POSITION of THE CHIROPRACTIC FAMILY PHYSICIAN

In a recent letter to the President of the Council on Diagnosis and Internal Disorders one of our leading educators commented that there is some concern between this Council and the post graduate schools. For our part there is considerable concern in this Council that some schools lean so heavily on academic review courses that busy doctors refuse to continue spending their weekends and their money on material which is largely irrelevant to improving the quality of their services.

As the clinician in practice turns his attention more and more toward the family practice he realizes that he needs a lot more clinical information in order to know more about providing adequate conservative care to types of patients that he had been referring outside the profession.

We are challenged as a profession to provide adequate conservative care which will bypass the iatrogenic hazards of the current medical industry. When hospital care can be successfully avoided by competent office or home services it is a great financial saving to the patient.

The courses in Diagnosis and Internal Disorders (constitutional and systemic disorders) provided by the colleges in their Post Graduate Departments must qualify the doctors who attend them to pass the examinations which our Council's Commission of Examiners prepares, and these examinations are going to be heavily clinical in order to enable our candidates to provide services that are broad in scope and assure a high degree of clinical success. There has to be a sharing of this common objective between our Commission of Examiners (representing this Council) and the Post-Graduate planning and execution of the courses provided. The point where the shoe is really pinching is that field practitioners will listen to instructors who have mature clinical experience and the more the better, whether they are D.C.s, D.O.s or M.D.s, but they will not stand still long for Ph.D.s or other academicians who have little or no clinical experience. This Council has the utmost respect and concern for the academic standards of the profession and for the necessary emphasis on research, but our immediate concern and responsibility is to very substantially increase the numbers of chiropractic family physicians (primarily health care providers) across the country, who can *really* deliver competent conservative health services. We earnestly solicit the aid and cooperation of the accredited colleges to provide courses which will achieve this objective.

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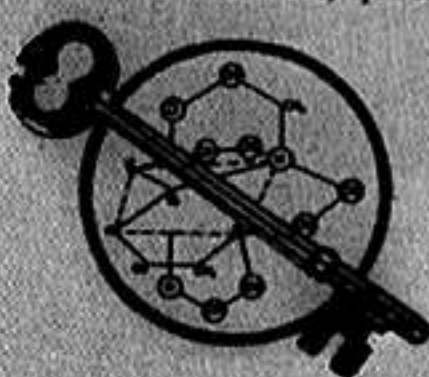
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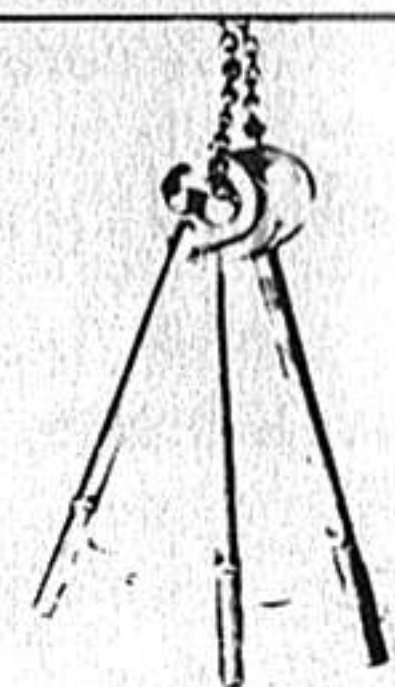
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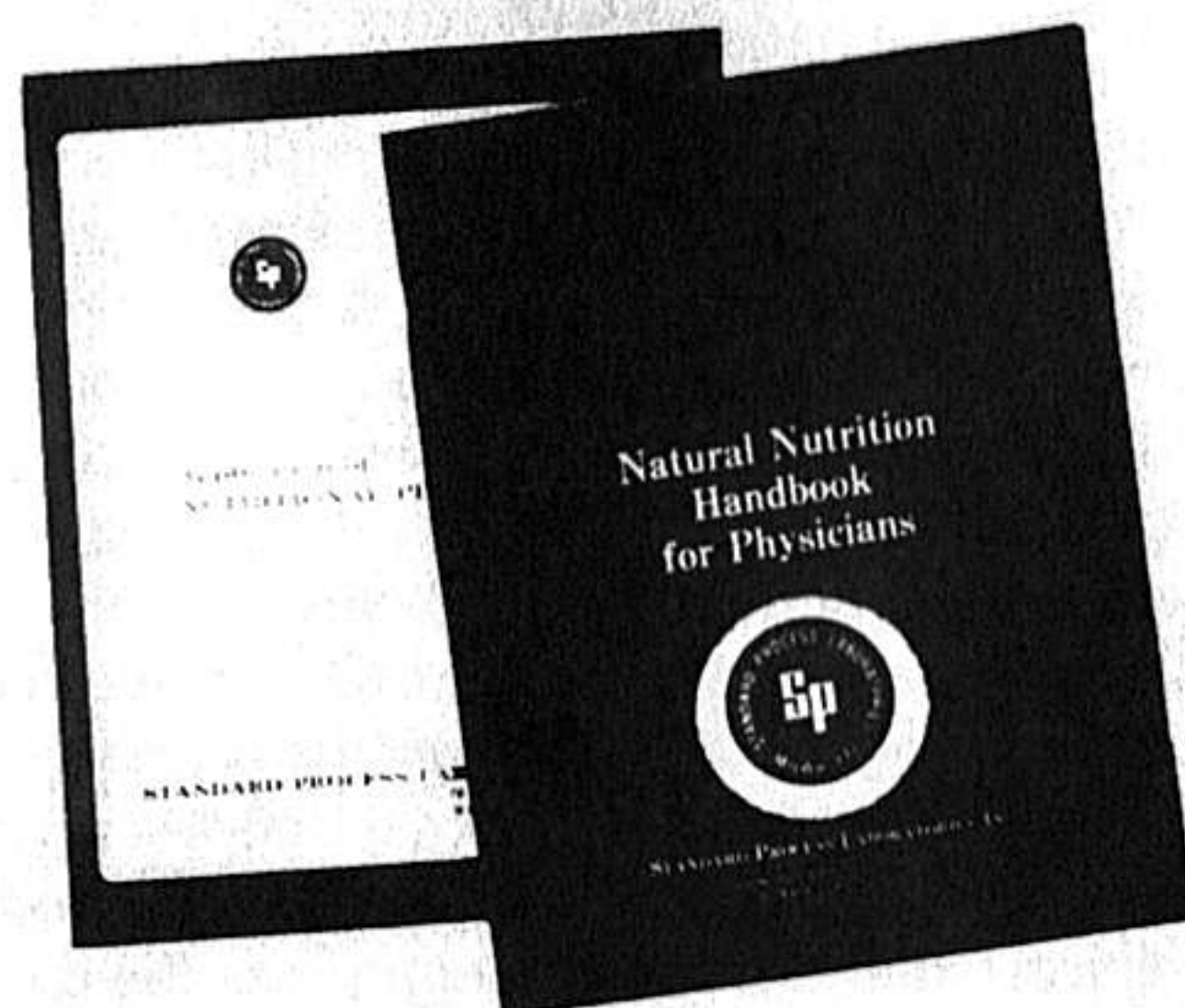


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BOOK REVIEWS

NEW DYNAMICS OF PREVENTIVE MEDICINE

Edited by Leon R. Pomeroy, Ph.D., F.A.P.M.

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All papers and discussions are primarily concerned with basic preventive clinical concepts with objectives to find better directions and methods than presently are pursued by the prevailing medical industry. A statement in the Introduction points out in substance that this work is dedicated to a 'new look' in medicine which addresses itself to preventive rather than 'crisis' care, and which seeks to pick up the 'early signals' of chronic degenerative diseases.

I am finding these two volumes rich and exciting with much useful clinical information. They are among the best investments in professional books I have ever made. I hope that many hundreds of my colleagues will acquire these volumes without delay and share my excitement in this new adventure in clinical horizons.

Note: Those clinicians who are interested in the use of orotic acid in practice will find much information in both volumes.

Ralph J. Martin, D.C.

BOOK REVIEW
DYNAMICS OF CORRECTION OF
ABNORMAL FUNCTION

The Lecture of T. J. Bennett, D.C.

Edited By:
Ralph J. Martin, D.C.

They say that there is nothing new under the sun, and yet we seem to constantly "discover" the old concepts. Certainly reflex points on the body have always been there, and for thousands of years used by Chinese through acupuncture. In more recent times, the virtues of Chapman reflex points from the osteopathic profession, and Applied Kinesiology, and Bennett reflexes from the chiropractic profession have been justly extolled.

Unfortunately, I went through school, as so many others have, with little formal training in reflexology. All that I learned on the subject I did from small study groups, reading on the subject, and from graduate courses. I can't imagine a drugless physician not wanting or needing some knowledge in this very viable diagnostic and therapeutic tool.

Few have had the opportunity to learn directly from one of the pioneers in reflexology within our profession. One such fortunate doctor was Ralph Martin. Dr. Martin first approached the course with Dr. T. J. Bennett with considerable skepticism. Impressed by Bennett and the concepts he promulgated in his course, Dr. Martin soon was integrating reflexology into his practice with great success. With considerable foresight, he transcribed the lectures into a collection of probably the most complete set ever put on paper.

Feeling that there was a need within the profession to be exposed to Dr. Bennett's work with greater accuracy than could be found from the hearsay of study groups, Dr. Martin has published a volume containing the Bennett lectures verbatim from April 19, 1959 through June 21st of the same year. This is all done in an attractive hard covered volume of 287 pages, and seventeen chapters, covering such diverse subjects as headaches, glaucoma, colitis, emotional problems and cardiac problems, and many more. Questions and answers germane to the subject being covered are also included. I did miss a table of contents and an index since this is primarily a reference volume. This fault has been ameliorated to some degree however, by giving a list of the subjects covered at the heading of each chapter. An appendix of charts with reflex points is also a useful addition.

Whether or not you plan to use the information stored in this volume is not the most important thing. What is important, I believe, is that every thinking physician regardless of his diagnostic or therapeutic persuasions should be *exposed* to a concept before judgement can be accurately rendered. I use Bennett reflexes in my practice to good effect, I have personally judged, and I have found "Dynamics of Correction of Abnormal Function" a necessary addition to my library.

Reviewed by:
Richard H. Tyler, D.C.

The Chiropractic
FAMILY PHYSICIAN

E.A. Wilson, D.C.

Vice President

Council on Diagnosis and Internal Disorders

(Continued from March, 1979 issue)

I will say this, when the catheter is used, we always have to bear in mind that sterile conditions must be adhered to at every step. When we are talking about catheters, colon tubes, when and where to use them, we come back once more to the necessity of diagnosis. The chiropractic physician who is well versed in the use of chiropractic physiotherapy as well as other drugless and conservative therapy methods, has a different if not as great responsibility for accurate diagnosis as the surgeon. However, any mistake that you and I might make in our diagnosis is completely out of proportion to what a surgeon's mistake could amount to. Yet a responsibility of accuracy in diagnosis and prescribing the treatment is an inherent responsibility of any and all those engaged in the healing arts, regardless of their school of thought and training.

I like to think (and maybe you do too) of chiropractic as embracing all the natural so-called drugless methods of healing, but emphasizing the basic principle of our profession which is spinal adjustment and general manipulation, without which many other methods lose their potential entirely. The salvation that we as chiropractic physicians can offer the sick and suffering is by artfully employing the various scientific methods of chiropractic physiotherapy along with our proven manipulative therapy. This is limited only by our ability to correctly diagnose these conditions. We must be able to discriminate between those conditions that are amenable to conservative treatment as compared to those that only a competent surgeon can remedy or provide suitable care. There is a two-sided responsibility involved in the examination of cases with a view to the propriety of chiropractic treatment. One desires to make all possible applications of an art that is capable of restoring health in so many cases without injury or loss of organs or life. The doctor should not make the mistake of employing his own methods where the indications of modern surgery are both proper and expedient. It is the abuse of, not the proper use of surgical methods that we strive to avoid.

A case in point involved my own wife. She had a ganglion that appeared on her wrist. You have all seen these things. Normally they are of no grave consequence and I waited quite a while before beginning therapy. I used galvanic, short wave diathermy and ultrasound for about a month or so. It became obvious that conservative treatment was to be of no avail, so surgery had to be done. Now this was another one of my many mistakes. I had let this condition go too long before I even tried treatment, consequently the surgery which should have taken about twenty minutes took almost an hour. This thing had grown around some ligaments and was pushing upon the radial artery. Proper diagnosis at an early date and proper treatment cannot be emphasized too strongly.

I would now like to relate a very simple case in which I found the use of the colon tube to be very helpful. One evening one of my patients called and reported that her son was having considerable pain in his right side and wanted me to take a look at him. I went to the home to see the 'little guy' who was thirteen years old and in bed of course. He was lying with his thighs drawn up to relieve the pain in his right lower quadrant.

I did the usual examination of chest and blood pressure, etc. He had a temperature of 100 degrees. There was pain at McBurney's point, pressure opposite McBurney's point produced pain at the point, so it was obvious that he was having some sort of inflammation of the appendix. In such a situation the main objective is to determine whether you have a surgical case or a case that will respond to conservative therapy. It is just as important to determine what something is not as to understand what it is. Now pain at McBurney's point can be produced by numerous things, colitis, iliocolitis, cholecystitis, cholelithiasis, localized peritonitis, ovaritis (but not in this boy's case) enteroptosis, bowel adhesions, hernia or ileocecal contraction. Appendicitis as you know with a few exceptions of course is a disease of the male predominantly, between the ages of five to twenty years. Here we have a boy of thirteen which makes him a perfect candidate for a surgical appendectomy. However there were no corresponding symptoms to indicate cholecystitis or cholelithiasis. It was easily ruled out that there was no hernia. There was not enough general abdominal tenderness to indicate peritonitis; bowel adhesions were very unlikely in a boy of this age, and then when I learned that he had not had a bowel movement in two days the picture was pretty clear. After I had made my examination my diagnosis was a simple congestive appendicitis . . . a serous infiltration into the vermiform appendix from an impacted cecum. I felt that all this boy was going to need was a good bowel movement and a spinal adjustment.

I therefore had him lie on his left side with his thighs drawn up to help relax the abdominal muscles. While in this position, I applied hard, deep pressure on both sides of the second lumbar vertebra. It did not take long for the pain to subside. I kept the boy on his left side and had his mother bring me enema equipment with plain warm water. I slipped the colon tube over the enema nozzle so I could use the colon tube as the sole application into the rectum. I lubricated the tube with KY jelly and inserted it into the rectum as far as I could without causing any undue pain or discomfort. I released a small amount of water. In a minute or two I was able to work the tube quite a little way into the colon. I then started releasing small amounts of water. When I had injected about a pint of water the boy said, "Doc, I got to go." I let him go but told him not to flush the stool. On observing the contents of the bowl there was an excessive amount of mucous with the stool. I then adjusted the boy thoroughly and in the course of the adjustment he had to leave me twice to go to the bathroom. When I left their house the boy was feeling fine and complained of being hungry.

Before leaving I advised the mother to keep him home from school the next day so I could get the excess mucous cleaned out of his system. If this is not done there can be a reoccurrence of symptoms and maybe the next time it would not be so easily

controlled. On the following morning I had his mother give him an isotonic salt solution. The purpose of this is to clean out the entire digestive tract. Such a solution is of the same specific gravity as the blood, and passes through the entire digestive tract without any interchange or absorption. It is made by adding one-fourth teaspoon of table salt to an ordinary drinking glass of water (lukewarm). This should be taken on an empty stomach and three more glasses of the solution, one right after the other, if they can get it down. This will pass through the system in about 20 to 30 minutes and does a very thorough job of eliminating mucous and all fecal material.

Incidentally the boy made an 'uneventful recovery' and this is just a rather routine general practice case which can be handled by any chiropractic family physician. The main thing in this case was the diagnosis. It could just as well have been a surgical appendix which would have been referred for suitable care.

CLINICAL ROUNDTABLE

Eugene J. Kraemer, M.T., D.C.

Case 78-FB

This case has been selected because it presents objective evidence of the effects of over-utilization of prescription drugs. This patient admitted to a routine of seventeen prescriptions used intermittently, with Prednisone being one of the most prevalently used. At this point she will slowly reduce so that in the next 30 to 60 days most of the items will be entirely discontinued.

In view of this history of over-medication the X-rays of the shoulders revealed at least extreme advances of osteoporosis, osteochondritis and massive occlusion of the joint spaces. Both humeral heads were involved with the right more seriously affected. It is also our opinion that some of the laboratory tests may have been influenced by the massive medication the patient received, thus making other possible problems.

Osteoporosis is one of the commonest results of over-medication and is referred to constantly through the contraindications of the Standard PDR. (Physicians Desk Reference).

The Case History:

This patient is a well nourished 56 year old Caucasian female, moderately over-weight, who came to this office on August 18, 1976 with the following complaints: 1) Dyspnea, 2) pain in legs, 3) Varicose veins, 4) pain in right shoulder, 5) variable blood pressure, high being 166/90, to low 124/76.

Previous History:

- | | |
|---------------------------------|---------------------------------|
| 1) The usual childhood diseases | 5) Sinusitis |
| 2) Influenza | 6) Phlebitis |
| 3) Possible Hay fever | 7) Asthma — since ten years ago |
| 4) Possible Rheumatism | |

(Continued on page 19)

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(Continued from page 17)

Family History:

- 1) Both parents deceased, cause of death: Heart disease, mother, age 79, Father 84.
- 2) Seven brothers, one sister, all living and apparently well.

Operations:

- 1) D&C
- 2) Removal of bone between toes.

Accidents:

No major accidents — only minor ones.

Habits:

- 1) Coffee: 2-4 cups/day
- 2) Tea, Tobacco and alcohol N/A
- 3) Cathartics: herbal types.
- 4) Drugs: (See Chart) Allergic to penicillin and aspirin.
- 5) Work: Housewife
- 6) Sleep: Intermittent due to the above conditions.
- 7) Exercise: Occasional

Marital:

- 1) Two grown children.

Comment:

This patient has been treated in this office occasionally since 1976 for the above mentioned conditions, utilizing physiotherapy, chiropractic adjusting, Reflex systems and the following food supplements:

- 1) Antronex — Standard Process Laboratories, Inc.
- 2) Thymex — Standard Process Laboratories, Inc.
- 3) Cal-Amo — Standard Process Laboratories, Inc.
- 4) Chewable Vitamin E
- 5) B-Plex — Anabolic Food Co., Inc.
- 6) Diet emphasis on green vegetables, proteins/acid balance.

On February 15, 1979 the patient came to me at the request of her personal Family Physician to inform me as to the kind of medication that had been given her by another physician. They are:

- 1) Prednosone in combination with mylanta
- 2) Morax
- 3) Ornade
- 4) Niacine
- 5) Synthroid
- 6) Zylprim
- 7) Motrin
- 8) The above medications were to be taken daily

(Continued on page 26)

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THE CLINICAL SIGNIFICANCE OF AUTONOMIC IMBALANCE

by Raymond H. Houser, D.C.

Editorial Comment:

This article, republished by permission of the author, details the academic knowledge regarding the subject of sympathetic/parasympathetic imbalance which in advanced stages is characterized as 'shock'. Shock is a very important clinical entity and must be recognized in both diagnosis and therapy. It is important in diagnosis because success in therapy is almost certain to fail when shock is present but unrecognized, no matter how thorough and skilled the diagnosis work-up may be otherwise.

Shock is not a static factor as might be mistakenly accepted from the physiologic information outlined in this article. As a matter of clinical experience the release of shock or the restoration of autonomic balance is one of the most dynamic phenomena a clinician may be privileged to witness. Since the physiologic facts are that all organs and glands are stimulated or inhibited by opposing autonomic controls, it stands to reason and is supported by clinical experience that very little can be accomplished in the treatment of individual organs, glands or systems in the presence of autonomic imbalance. As soon as autonomic balance is restored, the body's inherent recuperative powers are released and problems which had defied the clinicians' best efforts begin showing amazing response and functional competence.

In his classes in the 1940s Dr. Major De Jarnette taught a technique which was both a method of testing the patient for 'shock' during the physical examination, and also releasing and restoring autonomic balance. Over thirty years of testing and perfecting this method has resulted in the perfection of a clinical tool of basic significance, and is included, along with a vast amount of other new information in the curriculum approved by the Council on Diagnosis and Internal Disorders for status as 'Qualified Internist' taught in accredited chiropractic colleges.

Part I

Since nearly all the visceral organs are innervated through both the sympathetic and parasympathetic divisions of the autonomic nervous system which are functionally antagonistic, any disturbance in the balanced activity of the two divisions may result in disturbances of the visceral functions. Normally, the two divisions are tonically stimulated to maintain a physiological balance but this balance may be shifted in favor of one or the other of the divisions and thus inevitably create disorders of visceral function.

Sympatheticotonia and Vagotonia

The fact that an imbalance between the two autonomic divisions may underlie a large portion of visceral disorders was conceived several decades ago. It was recognized then, as it is now, that even individuals in an average state of health often show a slight predominance of sympathetic or of parasympathetic activity or that one individual was

more responsive to slight sympathetic stimulation than to fairly strong parasympathetic stimulation or vice versa, showing that the one division of the autonomic system was more tonically stimulated and thus presented at least a potential imbalance of clinical significance. These observations gave rise to the classification of patients as being sympatheticotonic or parasympatheticotonic (more commonly called vagotonic) depending upon which division presented the real or potential predominance.

From the standpoint of neurological imbalance, the activity of an organ or the body functions in general may be disturbed in favor of either the sympathetic or parasympathetic nervous system. Consequently, it is possible to classify the various visceral disorders into one of two groups: (1) those resulting from predominating sympathetic activity, or (2) those resulting from predominating parasympathetic activity. The imbalance may

be localized to one organ or one system or, at times, may involve the body functions generally so that the individual may be classified as being either sympathicotonic or vagotonic. It should be recognized at this point, however, that a relative sympathicotonia (either local or general) may exist in the absence of exaggerated sympathetic tonus when there is a subnormal tonus of the corresponding parasympathetic nerves. This also applies in the case of a relative vagotonia when there is a subnormal tonus of the corresponding sympathetic nerves.

Many writers have outlined a rather definite symptom-complex associated with the classical states of sympathicotonia and vagotonia. The symptoms and signs associated with an exaggerated sympathetic tonus include dilation of the pupil, protrusion of the eyeball, decreased lacrimal secretion, deficient salivary secretion, dryness of the mucous membranes, hyperthyroidism, tachycardia, dilation of the stomach, hypomotility of the stomach and intestines, hyposecretion of the gastric and intestinal glands and of the pancreas, and the atonic type of constipation. The symptoms and signs associated with exaggerated parasympathetic tonus include epiphora, contraction of the pupil, increased secretion from the mucous membranes as in catarrh and hay fever, hoarseness, excessive salivary secretion, asthmatic symptoms, bradycardia, hypersecretion of the gastric and intestinal glands causing hyperchlorhydria, hypermotility of the stomach and intestines showing as diarrhea or spastic constipation, and irritable bladder.

Classification of Patients

It is often advantageous to classify patients as being either sympathicotonic or vagotonic. The value in such classification lies in using it as a guide for therapeutic applications, in determining the characteristics of the patients and in forming an opinion as to the expected responses of the patient to treatment.

Sympathicotonic Patients

Sympathicotonic individuals have characteristics which generally enable one to identify them rather easily. They usually are tall and thin although the height may be altered from the characteristic by previous malnutrition or because of family traits. They generally are active and become impatient if work is not accomplished with the speed

which they like. Their actions and speech are usually fast and sometimes impulsive. In their intense desire to accomplish the work at hand, they drive themselves often to their own detriment. Their mentality is usually sharp. Their impatience and their dislike to remain quiet and relaxed usually classifies these persons as nervous. The greater the exaggeration of the sympathetic activity, the greater and pronounced these characteristics become.

Because of their refusal to rest more and to "slow down," the sympathicotonic individuals always are in danger of exhausting the sympathetic nervous system and the related synergistic endocrine glands. As a result, when these individuals finally reach the doctor's office as patients, they often are suffering from such exhaustion as shown in indigestion, low blood pressure, asthenia, nervous breakdown, neurasthenia or collapse. The treatment should include rest, a new mental outlook, plain but attractive food well masticated, avoidance of all excitement and worry, and the abstinence from sexual relations. These patients generally are difficult to control, however, because they crave excitement and action. Even when they do resolve themselves to physical rest, their minds and imagination are usually far too active and fired with ambition to gain the maximum benefit from physical rest.

In spite of the fact that the sympathicotonic individuals often are referred to as weak and sickly in appearance, they have a powerful defensive functions respond quickly upon the introduction of toxic or infective agents so that the temperature may rise on slight provocation and may go very high during acute infections. Such patients generally get over their illnesses quickly but are slow in recuperating due to the sympathetic depletion. Sometimes the sympathetics and the related glands may become exhausted during an acute illness and thus the defensive functions weaken and the condition may become chronic.

Because of the nature of the autonomic imbalance, sympathicotonic persons are particularly apt to suffer from dry catarrh of the sinuses and nasal passages the salivary secretions are apt to be poor in quantity and quality, the heart rapid or rapid upon the slightest exertion, and the stomach and intestines underactive with resulting poor digestion and constipation.

Neurologically, sympathicotonic patients should have stimulative treatment in the cervical, lower lumbar and sacral regions and sedative treatment in the thoracic and upper lumbar regions. It usually will be found that such patients like treatments on the neck and in the lower lumbar and sacral regions and since such treatments stimulate the parasympathetic systems and thus aid in neutralizing the overactivity of the sympathetics, they generally feel better. On the other hand, stimulative treatments in the thoracic region generally make them feel worse. This is not to be interpreted as advising against the correction of specific spinal lesions in the thoracic and upper lumbar regions of these patients. Such lesions in these regions very possibly may be causing stimulation of the thoraco-lumbar sympathetic nerves. It would seem advisable in such patients, however, to correct the specific lesions if they exist and then to give the thoracic and upper lumbar regions no further treatment that may give stimulation.

Vagotonic Patients

Vagotonic individuals frequently are classified as the anabolic type because of their tendency to build up and carry excessive fat. They usually are lovers of good food and consider eating as one of the chief joys of life. This, along with a lower rate of metabolism

and slower habits of living, generally gives them bodies of middle stature well covered with fat. They like the luxuries and comforts of life and usually are slow in their movements and activities. Vagotonic persons generally benefit by exercise because exercise stimulates the sympathetic nervous system. However, they usually dislike exercise and consequently, if exercise is taken, it usually is in the form of a game.

Individuals who present a vagotonia are more apt to suffer from catarrhal conditions, asthma, digestive disturbances resulting from overactivity of those organs, spastic constipation, diabetes mellitus, infections and obesity. During illness those of the vagotonic type do not respond with rapid stimulation of the defensive mechanisms of the body as do those belonging to the sympathicotonic type. As a result, illnesses are apt to be more prolonged but recuperation rapid.

Neurologically, vagotonic patients should have stimulative treatment in the thoracic and upper lumbar regions and sedative treatment in the cervical, lower lumbar and sacral regions. This procedure stimulates the sympathetic system which neutralizes the overactivity of the parasympathetic nervous system. Likewise, they respond well to increased activity or exercise, massage and the Turkish bath type of elimination.

Part II

Symptomatology of Autonomic Imbalance

That a disturbance in the innervation of any particular tissue or organ will cause a disturbance in the physiological function of that part is a fundamental fact. Symptoms, then, become the outward manifestation of disturbed function. In clinical practice it is important that the symptoms which may result from the two types of autonomic imbalance be firmly fixed in mind and so for more convenient reference, these symptoms are tabulated below under the headings of the various visceral parts.

Eye and Lacrimal Glands

Predominance of the sympathetic innervation to the eyes and lacrimal glands shows itself by a dilation of the pupil, a widening of the palpebral fissure, an apparent protrusion

of the eyeball and an abnormal dryness of the eyes.

Predominance of the parasympathetic innervation is indicated by a contracted pupil and an increased lacrimal secretion called epiphora.

Mucous Membranes of the Head

Predominance of sympathetic impulses leads to an underactivity of the glands and a constriction of the blood vessels of the mucous membranes. As a result, upon observation, the mucous membranes appear pale and subject to unusual dryness.

Predominance of the parasympathetic impulses leads to a dilation of the blood vessels and an excessive secretion from the glands. Upon observation, the mucous membranes appear reddened and swollen and show signs of excessive mucous secretion. This

form of disturbance is found in hay fever, sinusitis, rhinitis and pharyngitis. As a result of the functional change already mentioned, the mucous membranes become excessively sensitive and irritable so that the slightest irritation usually evokes sneezing.

Salivary Glands

A decrease in the secretion of the watery components of the saliva is brought about by a predominance of sympathetic impulses reaching the salivary glands. This is a notable finding in any acute disease in which the patient complains of a dry mouth.

An increase in the watery components of the saliva is brought about by a predominance of the parasympathetic impulses reaching the salivary glands. This sometimes is seen as a reflex manifestation of certain gastric and pulmonary disorders not associated with an acute toxemia.

Thyroid Gland

Stimulation of the sympathetic nerves to the thyroid gland increases the production and secretion of thyroxine. The excessive secretion in turn acts as a stimulator of the entire sympathetic nervous system. This may be observed in hyperthyroidism or exophthalmic goiter.

A few branches of the vagus nerves have been traced to the thyroid gland but their stimulation seems to produce no changes in the function of the gland.

Bronchi and Lungs

Sympathetic predominance to the pulmonary organs leads to a vasoconstriction of the blood vessels, a decreased secretion from the glands of the mucous membrane and a relaxation of the small bronchial muscles.

Parasympathetic predominance to the pulmonary structures frequently is seen in practice. The results of such disturbances of the innervation is shown as a vasodilatation, increased mucous secretion and a constriction of the small bronchial muscles. As a result, difficulties in breathing and an oversensitivity of the bronchial mucosa may be experienced. The entire syndrome is observed best in cases of asthma. Parasympathetic predominance is further associated with bronchitis, tuberculosis and emphysema.

Heart

Predominance of the sympathetic innervation leads to an increase in the rate of contraction of the heart muscles with a corresponding increase in the force of contraction. This finding frequently is observed in any disorder associated with a general sympathetic stimulation such as in hyperthyroidism or acute toxemia.

Predominance of the parasympathetic innervation leads to a decrease in the rate and force of contraction of the heart muscles. There also is an interference in the passage of the impulses over the intrinsic nerves of the heart and thus the rhythm may become irregular. Experimentally, vagus stimulation has been made to produce heart block.

Stomach

Predominance of the sympathetic innervation to the stomach leads to a decrease in the tone of the gastric musculature, a constriction of the blood vessels, an inhibition of the gastric secretions and a diminution of the normal motility of the stomach. These functional changes may give rise to a wide variety of symptoms. Upon fluoroscopic or radioscopic examination, the stomach generally appears to be large and underactive so that it empties slowly and incompletely. A gastric analysis usually reveals a hypochlorhydria and thus the digestion of proteins is retarded with resulting decomposition of the food masses in the stomach giving rise to gas, nausea and even vomiting. Even slight predominance of the sympathetic innervation to the stomach impairs the appetite since appetite depends upon the normal contraction of the stomach walls and the secretion of gastric juices.

Predominance of parasympathetic innervation is associated with overactivity of the gastric functions. It results in an increased tonus of the gastric musculature with a hypermotility and a hypersecretion of hydrochloric acid. Fluoroscopic or radioscopic examination generally reveals a small, overactive stomach which empties prematurely and a gastric analysis reveals a hyperchlorhydria. Since the stomach empties prematurely, followed by the secretion of the gastric juices, the hydrochloric acid irritates the walls of the empty stomach and may give rise to hunger pains. Overactivity of the parasympathetics to the stomach is associated with hyperacidity of the stomach and

gastric ulcer. Likewise, the functions may be similarly reflexly disturbed as a result of inflammations in other organs reached by the vagus nerves.

Small Intestine

As in the case of the stomach, sympathetic predominance in the innervation of the small intestine leads to a vaso-constriction with an inhibition of the motor and secretory functions. As a result, intestinal digestion and absorption is impaired and the passage of the food masses through the intestine is delayed.

Predominance of parasympathetic impulses reaching the small intestine leads to a hypersecretion and an overactive peristalsis.

Large Intestine

Sympathetic predominance to the colon and rectum results in a decreased tone of the colon muscles, a vasoconstriction, a decreased secretion from the glands of the mucosa and lessened peristalsis. This leads to the flabby, dilated colon seen in atonic constipation.

Parasympathetic predominance results in the production of an excessive tonus of the muscles of the colon along with an excessive secretion from the glands. As a result of the hypermotility, either diarrhea or spastic constipation may occur depending upon whether the circular or longitudinal muscles of the colon are involved. The increased secretion is best seen in cases of mucosus colitis.

Liver and Gall Bladder

Since the sympathetic impulses inhibit the contraction of the gall bladder and con-

sequently is complete emptying, a sympathetic predominance may predispose of the formation of gallstones and cause a deficient flow of bile into the intestinal tract during digestion. The sympathetics, it is said, also inhibit the secretion of cholesterol in the bile and consequently sympathetic predominance possibly may be a factor in the disturbance of the cholesterol balance in the body.

Disorders Associated With Autonomic Imbalance

From the foregoing, it may be learned that a large number of specific disorders may result from autonomic imbalance. The classification or grouping of the disorders, at least in part, lays the foundation for the type of treatment to be followed as far as that treatment will affect either branch of the autonomic nervous system. As a summary of the above discussions, these disorders are classified and repeated below.

The disorders most commonly associated with a sympathetic predominance are hyperthyroidism, dryness and paleness of the mucous membranes of the head, deficient salivary secretion, tachycardia, dilation of the stomach, hypochlorhydria, poor digestion and atonic constipation.

Disorders associated with a parasympathetic predominance are epiphora, hay fever, sinusitis, rhinitis, pharyngitis, excessive salivary secretion, bradycardia, asthma, tuberculosis, hyperchlorhydria, peptic ulcer, diarrhea, spastic constipation, mucous colitis and anaphylaxis.

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(Continued from page 19)

Others prescribed on a PRN basis include:

Potassium Iodide	Aminophyllin
Hydrodiuril	Sudafed
Premarin 2X/week	Isuprel
Bronkometer	Ampicillin

Tetracycline was discontinued a few weeks ago.

On February 20, 1979 a profile (panel) 99B, Latex and Sedimentation Rate was performed and the following abnormalities were noted:

- 1) Na 147 meq (135-145 meq)
- 2) Cl 108 meq (96-106 meq)
- 3) LDH 268 U/L (100-225 U/L)

Note: In order to differentiate between liver and heart, we should logically have performed LDH Iso-Enzymes. We did not have the opportunity to do so at this time as there was no opportunity to discuss it with the patient.

The CBC and Sedimentation Rate were essentially negative. Latex was negative (which in my opinion may have been due to the excess amount of medication given to the patient, thus masking the true answer to the test).

Urine: Essentially normal

Thyroid: T-3, T-4, and free T-4 Index were all within normal limits.

HDL, Chol/HDL, & Cholesterol were also within normal limits. Interpretation of X-rays of both shoulders, including humeral heads showed extensive erosions of osteoporosis, also osteochondritis partial filling the normal joint space.

In view of the extensive repair work required in both of the shoulder joints the patient was given Calcium and Magnesium Orotate in the hope that basis improvement might be possible. The dosage of each, Calcium and Magnesium Orotate 600 mg. daily, one tablet of each in A.M. and P.M.

Conclusion:

In view of the extensive erosion and infiltration into the joint spaces, basic metabolic repair will be required which will call for an adequate period of time for clinical results.

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References:

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Hi Richard:

I have been saying the same thing for many years, but, frankly, I haven't put it so nicely in words as you did in your article, "Is it time for a separation?"

Thanks for standing up and being counted.

It should be published in other chiropractic publications including the ACA Journal, CCA Journal and Chiropractic Economics, to mention a few.

Keep up with this kind of exposure and let the "straights" be glorified masseurs, if they want to. I'm with *you*!

Thanks again.

Jacques Blits, D.C.

Gentlemen:

I have been a chiropractic patient for the last five years and have recovered from a scoliotic illness which resulted in a medical diagnosis of permanent handicap or crippling which would result in an ability to walk.

Since that diagnosis I have done much research into the science of Chiropractic and with the help of several dedicated Doctors of Chiropractic, I am now not only mobile but have begun lecturing on the subject.

Today my D.C., Roger Nyberg, handed me his copy of *Chiropractic Family Physician*. I find it a very exciting journal and hope that I will be able to receive some of the research into physical diagnosis. Any papers which you have available concerning the diagnosis of endocrine disorders would be greatly appreciated.

The book review of *Essentials of Physical Diagnosis* by JD Kirby, D.C., does not give the name of the publisher. Am I to assume that this book is available through your organization? I am interested in purchasing it to further research for my lectures concerning the science of Chiropractic. Please advise me concerning a source for purchase.

I would be interested in receiving any information concerning availability of your councils research to non-members of the Chiropractic profession.

Etta K. Brown, B.S., M.Ed., ED.S.

Licensed Dental Hygienist

Dear Dr. Tyler:

Your article, "Growing Up" could hardly have been said better. Obviously, I am biased in making that observation, for I agree with you.

T.L. Shrader, D.C.

Dear Dr. Tyler,

I am writing to congratulate you on your fine article against "straight chiropractic." I too, am concerned with the restrictions and impositions that these groups wish to place on our profession. As a physician practicing in New York, I am fortunate that my state prevents these practitioners from entering and establishing. However, I can only fear what results and changes will be made if we allow a marriage between opposing forces. I feel, as members of the second largest health profession, we have an obligation — morally, ethically, or otherwise — to provide the finest possible care and service to the public. I am convinced that this must include diagnosis and diagnostic equipment, modalities, and any other means at our disposal.

Persoanly, I find it insulting and degrading that institutions such as Life, Sherman, ADIO, and any other similar group can award the title "Doctor of Chiropractic" to its members, the same title which I have earned and deserved. Perhaps instead of a separation between these groups, we should work to prevent the future of "pseudo-chiropractic." After nearly 85 years of consistent struggle and gains, chiropractic does not need nor can it afford to regress.

I hope that you will continue to speak out in editorials against this threat from within our ranks. Their support is strong, active, and growing — please do all you are able to stem the tide.

James T. Bartz, D.C.

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June 16-17

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This Council accepts candidates for 'Qualified Internist' or 'Diplomate Internist' examinations who have taken the required number of graduate hours of advanced clinical courses in an Accredited Chiropractic College. This Council does not engage in any educational activities outside the C.C.E. educational system.

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THE CHIROPRACTIC FAMILY PHYSICIAN

JULY 1979

VOL. 1, NO. 5



"DYNAMICS of CORRECTION of ABNORMAL FUNCTION" TERRENCE J. BENNETT LECTURES

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By

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the Chiropractic FAMILY PHYSICIAN

JULY, 1979

VOLUME I, NO. 5

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SALUTE TO DR. VAN D. MERICAS, D.C.

Dr. Van D. Mericas was the second president of the Council on Diagnosis and Internal Disorders, serving from 1973 to 1975. Acting Mayor of Dearborn, he is a longtime prominent community leader.

The 62-year-old chiropractic physician was appointed to fill interim terms on the Dearborn City Council in 1967 and 1970.

He has served as an elected councilman since 1970, winning the council presidency in 1972 and again in 1977. As mayor pro tem, he assumes the duties of city leader during the incapacitation of Dearborn Mayor Orville L. Hubbard, who suffered a stroke three years ago.

Active in community affairs, Dr. Mericas is president of the Dearborn Chamber of Commerce and director of the Community Task Force to Combat Drug Abuse. He was a member of the Dearborn City Beautiful Commission from 1958-64 and served as chairman from 1962-64.

He is a former vice chairman of the Henry Ford Statue Committee, past president of the East Dearborn Kiwanis Club, former secretary of the Dearborn Housing and Urban Renewal Committee and past president, secretary and treasurer of the Inter Service Club Council of Dearborn.

Dr. Mericas was named Dearborn "Father of the Year" by the East Dearborn Merchant Association in 1960 and "Member of the Year" by the Inter Service Club Council of Dearborn in 1975.

He holds other memberships in Ford Dearborn Post 1494 of the Veterans of Foreign Wars; Dearborn Moose; Dearborn Civitan Club; Olive Branch Lodge No. 542, Free and Accepted Masons; Detroit Commandery No. 1, Knights Templar; and Dearborn Shrine Club.

The acting mayor was born in New York City March 9, 1917. A 1940 graduate of New York's Columbia Institute of Chiropractic, he received his D.C. degree from the National College of Chiropractic, Chicago, in 1946, and followed it with post graduate work at Wayne State University in Detroit.

A member of the Michigan State Chiropractic Association and the Council on Diagnosis and Internal Diagnosis, Dr. Mericas is vice-president of the Foundation for Chiropractic Education and Research and past governor and chairman of the American Chiropractic Association.

During World War II he served as a pharmacist with the U.S. Coast Guard Reserves from 1941-46 and was stationed in Europe and North Africa.

He and his wife, Kristalia, are active in the Dearborn Orchestral Society and SS. Constantine and Helen Greek Orthodox Church of Detroit. They have two daughters, Sia, 22, and Katherine, 18.

"DIVIDED WE STAND"

by
Richard H. Tyler, D.C.

I am *not* a chiropractor. I know I have the Doctor of Chiropractic degree but I don't think of myself as a chiropractor. I am a doctor — a physician — my *specialty* is chiropractic. My *first* loyalty is to the welfare of my patients *not* the name "chiropractic". Chiropractic is not synonymous with the patient's welfare. It is a viable approach to the maintenance of health but it's not a panacea. How often I've heard those monocausal madmen spouting incoherently about "universal intelligence" and "innate" curing everything. If innate is so all powerful, why does any well-adjusted person ever get ill? Yes — structural integrity is important and I love to adjust but I have enough common sense to realize that it — like any other therapeutic approach — has its limits.

Unfortunately we are irrevocably linked to the lunacy of a small but vociferous group of fanatics. Fanaticism, whether it be in a jungle clearing with a religious cult, or in the halls of congress, can spawn sickening and potentially dangerous consequences. Recently a group of "our" fanatics did their act before a congressional committee with almost disastrous results. At issue was the certifying of the CCE as the accrediting agency for the profession. By the time the "super straights" were through assuring the committee that we were stupid and inadequately trained to do anything but crack backs, it was all the CCE could do to get an extension of one year instead of the usual three. There was even talk among the committee members about the profession losing most of the benefits we may already have. Even the ICA felt the need to send a letter to its membership expressing its embarrassment and lack of support for this small band of cult chiropractors.

When pressed by the members of the congressional committee the fanatics had to finally admit that the total membership of their cult included approximately 600 "doctors" and *students*. We probably have the dubious distinction of being the only profession in the healing arts in which its quacks are organized — with *officers*. So here is the situation, a rather classic one, in which the tail is literally wagging the dog. Many thousands of well-educated chiropractic physicians being politically buffeted about because of the incoherent mumblings of a small band of driven and dangerous cultists. And there's no reasoning with them. They won't *let* the rest of us practice in peace as our consciences might dictate. They don't even want their students to be *exposed* to something they might disagree with. They want to burn the books and control the thought processes in a blatant display of contempt for the intelligence of those who attend their "schools". You must practice chiropractic in order to be a chiropractor.

Recently I read an article that had the super straights crowing triumphantly about a decision by the New Jersey supreme court in which it was stated that the CCE indeed represented the "mixer" approach as opposed to the "straight". That there were *two* professions. For once I am in total agreement. There *are* two professions.

I once wrote that we should have a separation. Now let's make it a divorce. In the settlement I wanted all the diagnostic tools and the modalities but that apparently

Continued on page 9

THE CHIROPRACTIC FAMILY PHYSICIAN

by

Eldred A. Wilson, D.C.

Vice-President, Council on Diagnosis and Internal Disorders

Doctors, this will be an attempt to introduce to you some of the ways and means that are involved in a general chiropractic practice, in which the chiropractor is in the role of a primary care health provider. If you have not already read Dr. Earl Homewood's article in an issue of last year's Chiropractic Economics, "The Primary Care Health Provider," I suggest that you read it. It is a splendid article, well-written and it puts the primary care health provider right up front where he belongs.

Much has been spoken and written about the chiropractic profession and its role as primary care health providers but little has been said about what such a position entails and what the D.C. could expect in the way of demands on his time and on his ability. I do not believe our doctors have been told that if we accept this role as primary care health providers, our days of seeing patients three or four days a week are over. I do not believe that we have been told that our 2 to 4 office hours will have to be scratched. Nor have we been told that when it comes time to take a vacation that you will either have to get out of town, get out of sight, get completely away from any telephone, or you will spend half of your vacation wondering why you took one at all.

This introduction is not a classroom resume of what it might be like to be a family doctor and it is not a chapter on the life of a family doctor, but instead it is an attempt at a presentation by a field practitioner who has been on both sides of the fence. I will not burden you with my life's history, but I will tell you that I developed a general practice as a matter of pure survival. I am in a small country town and I came here from metropolitan Kansas City, Missouri where I had practiced for a number of years. Apparently I was practicing as a technician although I thought at the time that I was a doctor. But since being here in this practice, I realize that I had been fooling myself considerably for a long, long time. I was only a technician and not a physician. If we are going to continue our efforts to secure our position as primary care health providers we must be ready to accept this challenge, and challenge is exactly what it is.

We are challenging allopathic medicine. We are telling the allopath that we are ready. The ingredient of being ready is versatility so we will have to adopt some of the ways of the old horse and buggy doctors as Dr. Homewood has stated in his article.

It is obvious that those who are sick that we are to care for, may well be on a 'do it yourself' basis. We do not have access to emergency rooms at hospitals where we send our patients with trained personnel to take over. Until we do, we are going to have to work very hard to prepare ourselves to bridge the gap between technicians and physicians, and this, doctors, is quite a gap. We will have to devise means to accomplish what has to be done with what we have to do it with, especially on house calls. You are going to have to make a diagnosis under very adverse conditions at times in order to treat the patient with any degree of success at all. You are going to have to be willing to make a house call in the middle of the night and be up half the

night and still work the next day. You are going to have to be mentally and emotionally ready to watch a patient die while you are doing all you can to help that patient to live. And what is even more trying is to determine, after it is all over, if this patient died from a condition that should have been treated by some other discipline than yours.

You are going to have to know something about home nursing care because you are not going to be able to go to a nurse's station and write some orders on the chart, then walk away. You will not only have to know what has to be done as far as nursing care is concerned, you will have to know how to do it. Then you can train some member of the family or friend of the family for them to do it. It is not a big thing, just a number of small things such as how to ventilate a room without a draft on the patient, and how to bathe that patient in this ventilated room without a draft. You must know what foods should or should not be served to your patient. You should know how to prepare the patient and give an enema and you should know how to catheterize a patient in the event it is necessary. There are so many things to take into consideration if we are going to be primary care health providers, and frankly, I do not believe we are ready, except in a few specially experienced individuals. But doctors, we can certainly get ready. It is not all that terrifying or all that impossible. A general family type practice is both satisfying and nerve wracking at the same time. It is both pleasant and at times frightening, but as things stand right now I would not trade my practice for all the specialties our profession has to offer. You may not make as much money but you will have a deeper satisfaction in your practice; you are going to feel like you have accomplished more. You are also going to become more and more involved in the lives of people and you are going to have to love people to do this.

I think we fit in perfectly as family physicians. However, you are going to have to come down from your ivory tower and be ready to meet people's aches and pains, head on. If we as a profession are going to accept this responsibility, we are going to have to learn to know at least a little about a very wide variety of ailments. Also, you are going to have to know something about drugs, yes indeed. That does not mean that you are going to use them, but it does mean that you must know something about them as to why and when they are used. Patients are going to bring in their prescriptions or bottles of drugs prescribed by their medical doctors, and want to know about them. You cannot just sit there on a pedestal and say "I'm sorry, I do not believe in them, so I cannot tell you anything about them." Whether we like it or not drugs are here and you are the person who should be able to tell them what a drug is used for and also what the contraindications and side effects may be such as allergies and synergistic reactions when more than one prescription is being used.

After this, you have professionally and intellectually told the patient just exactly what they wanted to know and what they should know. If you do not know what a medicine is or what it will do, why should you tell them that it should not be used? After you have explained the drug or prescription to them it is easy then to say that you do not use it because there are better and safer ways to treat the condition. You will be surprised how people will then go along with you after you have given them the facts about the prescription which probably had not been explained to them before. You do not have to take a course in pharmacology to tell people these things. The best thing to do is to keep an up-to-date PDR (Physician's Desk Reference) on

your desk and you have the answers at your finger tips. Current drugs are alphabetically listed; they tell you what they are, what they are used for, usual dosage, and possible contraindications and side effects.

A patient with some heart trouble in addition to her diabetes asked me about Orinase. I told her I would look it up and see what the big book had to say about it. I found the right place and let her read the contraindications and adverse affects.

After she had read what the medical profession had to say about Orinase she asked me "Why did not my medical doctor give me this information?" Now she is controlling the blood sugar nicely with diet alone, and is now completely my patient.

We must be more aware of the original tenets of chiropractic which asserts that the nervous system directly or indirectly controls the majority of diseases from which mankind suffers. This premise is well supported by scientific literature and the accessibility of the nervous system is not limited to the spine alone.

The spine is not the entire answer. Nerves, ganglia, fibers, neurons course and ramify through every tissue of the body. There are innumerable factors that are concerned to initiate irritation in some part of the nervous system. This includes musculo-skeletal distortions, mental and emotional conditions, dietary indiscretions and deficiencies, injuries, pain, accumulations of toxins from excretory organs, all resulting in various abnormalities. Exogenous and endogenous toxins, bacterial and parasitic organisms with their toxins all contribute to human illness. Disease often results from a constellation of many factors; however, in some way disturbances of the nervous system are always involved. We should, as physicians, endeavor to relieve these disturbances whenever they may be found to exist without any damage to the patient. Relief from spinal stress must be relieved by an adjustment or other manipulative means as may be indicated. Very often in addition to the adjustment, conditions may necessitate the use of other material measures such as rest, exercise, diet changes or even psychotherapy. In order to treat the majority of man's ills the chiropractor physician must realize the need for methods which can correct or assist in the correction of all the varieties of nerve irritation. We as physicians need to study each case, not only in reference to the symptoms but more importantly in reference to the patient, his environment, physical structure, his mental attitudes, and his hygienic habits. We must remember that the patient as well as his disease must be treated.

If you choose to remain in your role as a healer with an approach of looking at nothing but the spine, if you are going to be content with the role of the spinal technician and confine yourself strictly to only spinal manipulations, this is your prerogative, but please move over and let some of the rest of us go on by and concern ourselves with taking care of sick people. You are only in the way. The chiropractic physicians are not going to bother you at all.

I would like to see all of us wake up and realize that maturity does not necessarily come with your diploma or your license.

IN MEMORIAM

Dr. George H. Haynes, whose picture appeared on the cover of the March, 1979 Chiropractic Family Physician passed, away on May 5th, 1979. He had been in ill health since 1976 and found it expedient to reduce his activities as President of the Los Angeles College of Chiropractic at that time. He had been dean of the college since 1954 and guided it successfully through many lean years, providing both inspiration and energy until the growth of the college required expansion and a new classroom building to provide facilities for over 600 students. The new building was completed while Dr. Haynes was still active at the college.

Dr. Haynes also headed the effort to gain Federal recognition of the Council on Chiropractic Education as the accreditation agency of the profession. To his everlasting credit, this was achieved in August, 1974 and was a major landmark for chiropractic educational institutions.

Dr. Haynes will be missed by his host of friends and many hundreds of students who benefited from the high standards of education which he maintained while they were in college at L.A.C.C. He will also be long remembered in the profession as one who gave his full dedication for the advancement of chiropractic. Dr. Haynes was recognized in Who's Who in Chiropractic, 1976-78.

Continued from page 5

wasn't good enough. What I forgot to ask was what the straights wanted in return. Now I feel I know the answer. They want the *name*. They want the name chiropractic. This is what it's all been about. So in this divorce settlement, I propose that we give them custody of the name "chiropractic". They can take it apart, play with it or molest it for all I care. You see, this may sound strange, but I care more about practicing the best kind of health care for my patients than about a set of letters. Call me what you will but I demand the right to practice with the tools I have been *taught* to use. If this means giving up a name — so be it. They don't want me or anyone else around who thinks differently than they do so let's give them what they want if in so doing it means professional survival and the right to practice as *physicians*.

I can already see all the worried compromisers predicting doom if we officially part. Well, I predict doom if we stay together. Unfortunately the public has the disturbing tendency to judge something by its *lowest* common denominator. If we stay with the cultists we can only degrade ourselves down to their level. Dividing *isn't* defeat, it's *honesty* and common sense. To be able to practice with honesty is a victory.

Therefore I propose that the ACA change its name and political thrust. Perhaps it could be called the American Physical Medicine Association or for the more sentimental the American Chiropractic *Physicians* Association. *Two* licenses should be granted — one to chiropractors or chiropractic technicians and the rest to drugless or chiropractic physicians. Whatever is done, the time to act is *now*. Remember, the welfare of the *ailing* not chiropractic is the supreme law and to rephrase an old saying "Together we fall — *divided* we stand."

A HYPOTHESIS

by
William A. Nelson, D.C.

There is a decision to be made by this profession. Are we to be known by the public for what we do or because of why we do what we do? Are we to continue being identified as technicians who move bones; specialized bone setters, if you will? Or, are we physicians interested in restoring health by influencing the nervous system? This latter situation may involve adjusting vertebrae but the goal of nervous homeostasis, nervous balance, is what identifies the chiropractor as a physician.

Since 1895 we have been using the vertebra adjustment as the sine qua non of chiropractic. For over eighty years the colleges have been extolling the basis of this profession as the adjustment of the spine. This is analogous to medicine's still teaching blood-letting in their colleges as a basic from which to grow. We cannot continue to saddle our students and inferentially our practitioners with concepts that are not valid in today's world.

In the past fifty years many new techniques have been developed that are clinically valuable. The field has been exposed to them by their developers and the schools have generally ignored and discouraged these competitors to education. The field is torn between loyalty to their alma mater and the pragmatic need to get sick people well faster. It is a fact of human nature that established institutions resist change with vigor. Change can be brought about by low level pressure and that pressure is starting to be felt, ergo, the introduction by limited exposure to students of some of the non-force techniques. The majority of effort is still being devoted to establishing that the adjustment works. After eighty years there is no doubt about this and we have seen only slight technical improvements made; we have not expanded our thinking. So we continue to waste our efforts going in circles instead of plowing new ground.

There is even a greater and more serious problem. We have lost our direction, our commitment is vacillating, our purpose is vague, our goal is indistinct in the distance. True, we have some zealots who have not faltered in trying to keep themselves as technicians, but who are compromising their integrity with food supplements and some soft tissue work, and they are moving into a more indefensible position than we.

It is alleged that chiropractic started out with the premise that a subluxation impinged a nerve and the patient's trouble started. That canard is being laid to rest. We recognize that the subluxation has something to do with the disease process and that correction of the subluxation will many times relieve the patient of his suffering. While we speak knowingly of correcting the subluxation, we also recognize that it is not as simple as that. After the adjustment the vertebra is often in the same place, even though the symptoms have ameliorated. We have tended to close our eyes to the incongruity between our statements and our actions. It is obvious the therapy lies in the thrust and not the replacement of the vertebra because too often the vertebra is not replaced although the symptoms are relieved. Let us be honest with ourselves

and recognize that correcting a subluxation is not our primary goal. Of first import is correcting nervous imbalance and the subluxation will consequently be corrected or correct itself.

The truth of the matter is that the newer techniques using the muscular system as effectors do in fact correct subluxations better, faster, and with more lasting effects for the patient. The clinicians in the field must get sick people well by the most expeditious means. They constantly seek more effective techniques. Change is stressful but to the clinician an unhappy patient provides even more stress so he continually seeks to improve himself, which neither the politician nor academician is required to do.

We now have a field composed of a veritable mix. Three groups stand out, the zealots, those who practice as originally taught, and a sizeable number who are studying, experimenting and searching for better ways of helping a suffering public, and the public is suffering. Ultimately the hodge-podge of techniques will be reduced as the least effective ones fall by the wayside. I suggest we cannot wait for this to happen. We must show professional progress to the public and the politicians. We need above all a hypothesis to replace the one cure idea. In the first place, we must get away from the image of chiropractic being solely linked to vertebrae, we must cease looking upon ourselves as technicians or allowing the public to so look. Our prime priority is to be recognized as doctors or physicians who use the nervous system for health restoration. We then become physicians using all the ramifications of the nervous system for the correction of disease. We are truly primary care health providers.

Continued in next issue

LETTERS TO THE EDITOR

Dear Dr. Martin:

Please find enclosed a check in the amount of \$20.00 for the purchase of one copy of "Dynamics of Correction of Abnormal Function".

I am very excited about these lectures and wish to thank the Council for its efforts at promoting the family physician concept.

I wish you all well.

John M. Cosgrove, D.C.

Dear Dr. Tyler:

What a pleasure to see a copy of your Family Physician Vol. 1 #4 of May, 1979.

We are now in our third generation of family health care under the guidance of Dr. William Nelson. If only more doctors and people could appreciate what a wonderful method he has for helping to achieve and maintain good mental and physical health.

Dr. Nelson has a combination of intelligence and integrity which gives high credibility to your profession and his treatment among those who know him. It is our hope that this growth toward treatment of health problems by means other than strict spinal manipulation will continue to prosper.

We are, and chiropractic should, be forever indebted to Dr. Nelson for his unswerving loyalty to a basic belief in chiropractic and its ability to expand as knowledge is gained.

O.D. Mashore & Family

Letters to the Editor Continued

Dear Dr. Nedzweck:

My compliments to the officers and editors of the *Chiropractic Family Physician*. It is indeed a publication that your good Council can distribute with pride. It is informative and clearly establishes the fact that chiropractors are primary health care providers.

I also wanted you to know how pleased I was to see Dr. George H. Haynes' picture on the cover and the tribute that our Council caused to have published in honor of a person who has been indefatigable in his efforts to serve our profession through research and education.

My warmest and most personal regards.

Ernest G. Napolitano
President

Dear Dr. Nelson:

There is an old saying "You are never too old to learn", and here I'm going to be 65 in June, out of school 40 years, Palmer, 1939, seriously thinking of going into semi-retirement, and POW. I get a copy of "Dynamic of Correction of Abnormal Function" by Dr. Bennett and my interest in the sick has just hit 1000! I knew about reflexes and the stretch, but some of the other areas of treatment and how it effects the human, particularly cranial etc. is great, so it looks like I'm going to continue working for a while, all because of the book, which incidentally has raised some questions which I hope you will take the time to answer.

V.C. Galante

Dear Dr. Tyler:

Your publication recently printed a letter to the editor from James T. Bartz, D.C.

In the letter, Dr. Bartz says "persoanlly (sic), I find it insulting and degrading that institutions such as Life, Sherman, Adio, and any other similar group can award the title Doctor of Chiropractic to its members. . . ." I think it is unfortunate that your publication printed this letter without comment. Life Chiropractic College presently has C.C.E. affiliation and should not be included with Sherman and Adio.

It is also interesting to note that Adio is prohibited by the State of Pennsylvania from awarding the Doctor of Chiropractic degree. Both of these facts are things an editor should have been aware of and made comment of after printing the letter.

James D. Edwards, D.C.

"I agree, I have met and conversed with Dr. Sid Williams. While we may not agree on everything, I found him a man of integrity devoted to exposing the students of Life Chiropractic College to the best form of educational progresses possible." — Ed.

DONALD P. LENGWIN, D.C.
2806 Anderson Drive
Allison Park, PA 15101

April 24, 1978

Dear Dr. Martin:

Where can I get an Ohm Meter like the one Dr. Bennett used in treating strokes? I have a close friend who just had a stroke and I would like to help him if I could. "Dynamics of Correction of Abnormal Function" is the most fantastic book I have ever read. I use it daily in my practice with some great results. I only wish I could have taken classes from Dr. Bennett, but at least I have the Book.

Sincerely,

Donald P. Lengwin, D.C.



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INTERPROFESSIONAL DIALOGUE

It was recently decided by your editorial board that an input on diagnosis in the form of a roundtable discussion with different members of the healing arts might prove of value. With this in mind, a meeting was held and the conversation taped in the latter part of 1978. The participants included:

Ronald M. Lawrence, B.S., M.D. — a prominent author and lecturer specializing in neurology.

J. G. Anderson, D.C. — instructor in clinical neurology for many years and former Dean of the Los Angeles College of Chiropractic.

Ralph J. Martin, D.C. — Certified Chiropractic Internist and former President of the Los Angeles College of Chiropractic, and Chairman of L.A.C.C. Board of Regents, 1972 to 1977.

Richard H. Tyler, D.C. — Board Qualified Chiropractic Orthopedist.

What follows is but a small portion of our recorded meeting. Due to its length and potential interest the "roundtable" may be continued over the next several issues. We hope to continue this series of conversations with other qualified individuals as a regular feature of the Chiropractic Family Physician.

INTERPROFESSIONAL DIALOGUE

(Continued from March, 1979)

Dr. Anderson:

To continue my response to your question, Dr. Lawrence, 'What changes have I seen in twenty-five years in the chiropractic profession?', I would concede that a great many of my cases came in for spinal adjustments, but even these will often say, "My stomach has been upset, but I know that if I get my back 'fixed' I am going to feel better."

Dr. Tyler:

Is that voluntary on the part of the patients or is it the result of your educational efforts with them?

Dr. Anderson:

No. It is just because they have experienced it, because I have not set out to educate them. I have never in my practice tried to look for systemic problems necessarily, but I have told them when I have adjusted them and they have a history of other problems which may be related, that the work done on the spine will have some good effects on the other disorders. It is amazing how many times it does, and they remember, so they come in. Sometimes then, when they have no spinal complaints they come in for systemic problems.

Dr. Lawrence:

The wonder of it is that the medical profession has been so short in their consideration of the nutritional areas. I have observed that the chiropractic profession has taken a great interest in nutritional factors and it is starting to seep through . . . the fact that if you have these internal systemic problems there is a valid nutritional approach to them. This is another thing that I observe all the time. I get a great many patients who come not so much with illness primarily but with questions, or asking advice on nutritional matters which obviously has been denied them in the allopathic offices. They seem to feel that the chiropractic physician is educated in these areas. I am not sure how this has happened, but they do feel that way. I suppose it may be a natural thing due to magazines like 'Prevention,' 'Let's Live' and many others which are probably the chiropractor's best friends.

Dr. Martin:

There is a religious magazine that has been very friendly to chiropractors . . . the Jehovah Witness publications, and their people are terrific patients.

Dr. Tyler:

Yes, I know, because I have dealt with them, but I think Dr. Anderson hit upon the important point in reference to the old family doctor. We do not have a replacement, but we are making an approach in the newer holistic concepts.

Continued to page 18

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Dr. Martin:

I heard Dick Sammons, Executive Director of the AMA say recently on T.V. that half of all medical college graduates are required to first go into a general practice, before they can branch out into specialty practices. But he did not say how long they had to be involved in general practice.

Dr. Lawrence:

I used to tell Dr. Tyler that no doctor should go into a specialty until he has practiced at least five years in general practice. That is not long, really. The general practice gives you a perspective that you do not get otherwise. The holistic approach then, as it is coming in is an attempt, and may be a good attempt, to recapture that situation as far as the general practitioner and the family practitioner has to come back into some sort of predominance if the allopathic profession is to maintain its position as a respected so-called leader in the health field.

This is a big thing too, because I know being involved with U.C.L.A. (University of California, Los Angeles) Department of Family Practice earlier, I realize that this is an area that is not to be ignored in the way that the young M.D. today is interested, if he is directed, or has some models to fashion himself after. In other words, if he admires family practitioners then he will direct himself toward this area of practice. Unfortunately, in medical schools most of the time the people that they model themselves after are surgeons, super-specialists, ultra-specialists, etc., and this is just the way it has been. A lot of the principles enunciated by osteopaths and chiropractors are of interest to general practitioners or family physicians. Now, to give you an example, here in our practice when I have demonstrated manipulative procedures those men that I have had with me and this would be as many as fifteen or twenty over the last twelve years who have not seen these procedures become so interested that they want to learn these procedures. Really, the final answer, the very compatible answer is that all three professions have to blend together. All three really can work together in this whole situation. You have to look at the totality, the holism of it all and this may be expressed somewhat in the American Holistic Association approach and their getting into manipulation and nutritional aspects of care of our patients. I think what has happened in the last century has been too much of a process of dividing things and categorizing the professions which we cannot continue to do.

Dr. Martin:

This is where the family physician comes into the picture because there has to be someone who puts it all together for the patient, instead of just chopping him up to one specialist after another until he does not know where he has been or where he is going.

Dr. Tyler:

At this time I wish to interrupt and get some comments from Dr. Lawrence and Dr. Anderson on the relationship of neurology and manipulation and other areas of their expertise in neurology.

The Council on Diagnosis and Internal Disorders hopes to stimulate interest in the profession in the Postgraduate courses which may be provided in the accredited colleges of the profession which will remedy feeling of inadequacy to practice as family physicians. In the alarming iatrogenic records which the medical profession has demonstrated we owe it to the public to provide health services that are both safe and effective. We invite you to participate in recording what chiropractic family physicians are doing.

This journal is published to alert the students and any doctors in practice of the limitless opportunities for service that are available to the Chiropractic Family Physician.

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CLINICAL ROUNDTABLE

Eugene J. Kraemer, M.T., D.C.

Case 79WS

This case was referred by a chiropractic physician who was familiar with the experience we have had with such cases and hoped some additional help could be found for him.

The patient is a 46-year-old Caucasian, well built and about six feet two inches in height. He presents a picture of chronic toxemia which is partially autogenic in origin and possibly also from extended exposure to toxic chemicals in years past when ventilation systems were not as efficient as they are today where testing of metals and chemicals is performed.

In order to determine whether his problems of fatigue, lack of energy, loss of normal 'drive' and general nervousness and depression were produced by some obscure pathology, or merely a low level of organic functional capacity, a laboratory 99B profile was done on January 24, 1979.

The factors of concern were noted in the results obtained from these tests: White cells are low-4300 and Total Bilirubin was high -2.6. In spite of this low white cell count the patient has not had a history of high susceptibility to infections. In order to further explore the high Bilirubin some additional tests were done on February 14; Serum Bilirubin -Direct and Indirect which produced a finding of Indirect Bilirubin of 1.7 mg. per 100ML, indicating possible hemolytic jaundice. Direct Coombs test gave negative result. This ruled out hemolytic anemia with possibility of Gilbert's Syndrome. Increased Indirect Bilirubin may indicate possible congenital hyperbilirubinemia. The 1.7 Mg. per 100 ML is a high reading which may be found in drug or toxic hepatitis.

In order to rule out hypoglycemia which his symptoms strongly suggested, a six-hour Glucose Tolerance test was done with only borderline indications. HDL was also borderline 'low', indicating possible risk of ischemic heart disease. This provided strong motivation for the disciplined rehabilitation program which was instituted.

With these findings plus very obvious physical indications of a chronic anoxemia, I decided to institute a three weeks' intensive care program to prove to the patient that he really could feel good and overcome all of his symptoms and enjoy a normal energy level. Daily treatments consisted of chiropractic adjustments with particular emphasis on normalization of every aspect of his nervous system, 10 minutes of oxygen at 5L, physical therapy to relax and restore a resurgence of circulatory velocity, plus a daily routine of physical exercise to assure a daily abundance of oxygen in his blood stream. Supplemental nutrition included chelated calcium and magnesium to repair any toxic damage to the myelin sheath of his nervous tissues and thyroid to step up his BMR.



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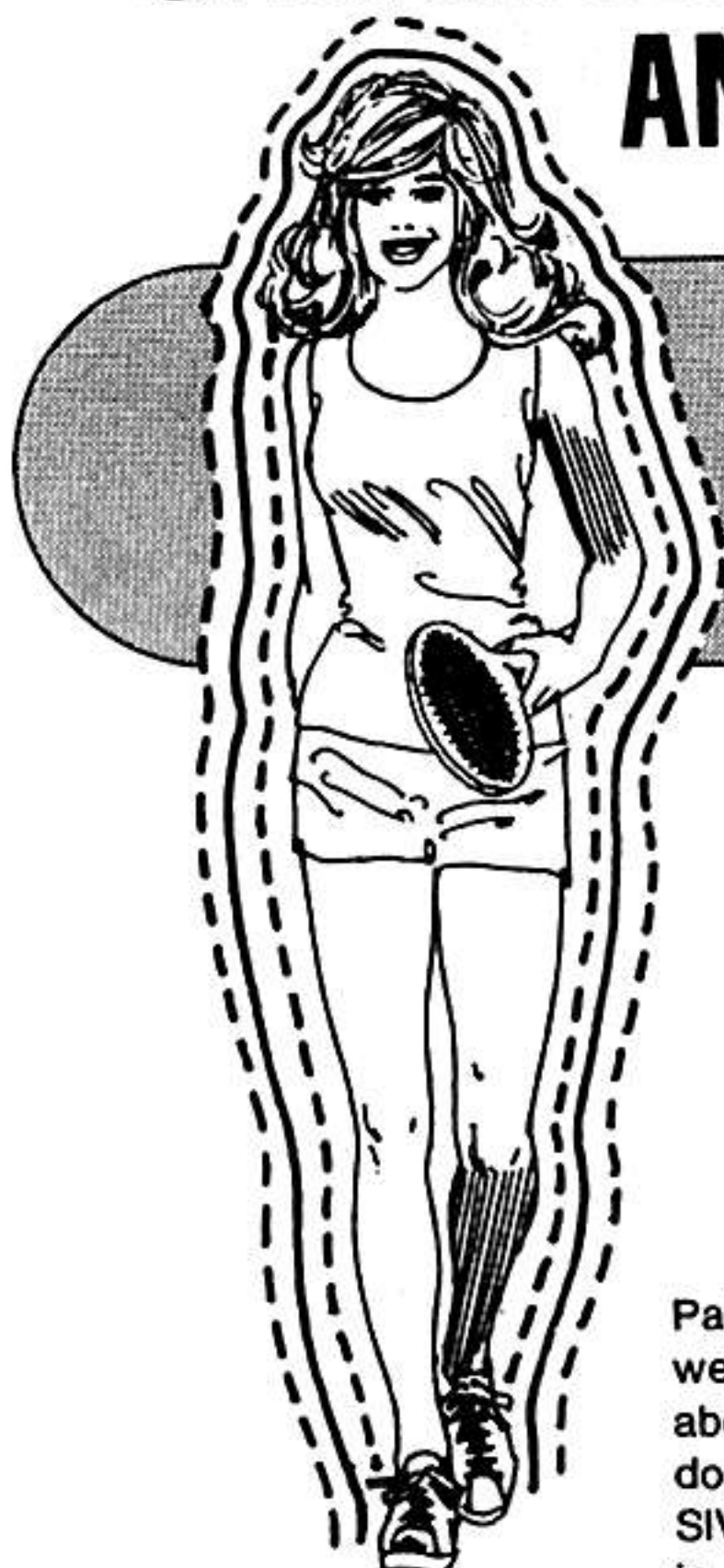
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THE OROTATES: Background and Clinical Uses

by David A. Rutolo, Jr., Ph.D.

There has been a great deal of interest recently in the use of orotic acid as a mineral carrier. This article will briefly review some of the chemistry of orotic acid and the clinical uses of its salts.

Orotic acid was first isolated as an unknown substance from the whey of cow's milk in 1905. Later, it was found in the milk of goats and sheep and, in smaller amounts, in the milk of humans, pigs and horses. Because of its growth-promoting property, orotic acid was initially claimed to be either related to "vitamin B₁₃" or part of the "vitamin B₁₃" molecule.

Recent measurement has confirmed the presence of orotic acid in both cow's milk and human milk. The concentration in cow's milk is relatively high. Commercial powdered milk also has a high content.

Orotic acid has only two known pathways of metabolism. One pathway is reduction to the amino acid, aspartic acid, carbon dioxide and ammonia. Most orotic acid, however, is converted in the presence of an enzyme and magnesium to a nucleotide which is then incorporated into ribonucleic acid (RNA), deoxyribonucleic acid (DNA) and certain enzymes.

TOXICOLOGY

Highly sensitive tests designed to study the toxicity of orotic acid and its magnesium salt on the central nervous system revealed neither substance had any adverse effect on the spontaneous vertical orientation activity nor on the learning process of healthy rats. On the contrary, they were found to expel or reduce the negative reactions of neurotoxic stress, induced by insecticides.

The long-term feeding of orotic acid to rats has been observed to produce a marked reduction in hepatic beta-lipoprotein release with an accumulation of cholesterol and triglycerides resulting in a fatty liver. However, the administration of orotic acid to mouse, chicken, and monkey has not been accompanied by the development of a fatty liver, suggesting a significant species variation.

A recent detailed clinical study in man concluded that the administration of 6 gm of orotic acid per day per patient produced "... no demonstrable evidence of hepatic dysfunction in any of the patients."

Investigators studying pernicious anemia noted that no toxic side effects were observed in treating their patients with 3-6 gm of orotic acid per day after 5-7 months.

As a result of a study on a therapeutic effect of orotic acid on arteriosclerosis, myocardial infarction and blood fat levels, investigators concluded that, "Orotic acid is practically non-toxic in therapeutic and super-therapeutic doses."

To determine the relative toxicities, several vitamins and related substances were injected intraperitoneally into rats in large dosages. The toxicity decreased in the following order: thiamin (B₁), FOLIC ACID, NIACIN (B₃), pyridoxine (B₆), orotic acid,

and ascorbic acid (C), indicating orotic acid was less toxic than vitamin B₁, folic acid, niacin, and vitamin B₆, while slightly more toxic than vitamin C.

In a recent review on orotic acid the author states, "No untoward effects arising from orotic acid administration to humans has been observed, though the feeding of orotic acid to rats can lead to disturbances in lipid metabolism."

NUTRITIONAL ASPECTS

While the need for orotic acid has not been established in man, it has been claimed to be a dietary essential for mice. An interesting observation in a nutritional study is that orotic acid, vitamin B₁₂, and methionine exert many similar effects in nucleotide metabolism of chickens and rats. All three compounds cause an increase in liver RNA content as well as an increase in the rate of turnover of these polynucleotide structures.

In the presence of either orotic acid or vitamin B₁₂, the protein incorporation of serine increased. These two factors similarly affect increased formate incorporation into RNA of liver cell fractions. It is, therefore, postulated that there may be a common role of orotic acid and vitamin B₁₂ at the level of the transcription process in m-RNA biosynthesis.

It has been suggested that orotic acid may lower the body requirement for choline through a metabolic interaction — orotic acid may stimulate the cytidine phosphate choline pathway of lecithin biosynthesis.

Orotic acid, when added to the diet of deficiently fed rats, prevented completely the marked, prolonged changes in reproduction seen in the control groups. Vitamin B₁₂ has a similar, though less marked beneficial effect. It was concluded that orotic acid, like vitamin B₁₂, has an effect on the biosynthesis, and hence availability of nucleotides with coenzyme activity.

SALTS OF OROTIC ACID

Of primary significance is the role orotic acid plays in active mineral transport. It forms a tight complex (cholate) with many minerals which penetrates the outer cell membrane intact and dissociates at the site of the membrane of the mitochondria and of other structures within the cell.

A. Calcium Orotate

Calcium orotate (300-600 mg/day) has been shown to be highly effective in treating patients with decalcification diseases, such as osteoporosis and juvenile decalcification. It restored to normal the level of serum calcium in 12 of 14 patients elevated because of osteoporosis, bony metastases, or cortisone treatment, while calcium lactate and calcium gluconate had the opposite effect. Large doses of calcium orotate (600-900 mg/day) given over a long period of time relieved pain in 21 patients with spondylarthritis.

In a two-year study involving some 55,000 daily doses, calcium orotate was found to produce a significant anti-inflammatory effect in the following conditions: arteritis, arteriosclerosis, with circulation disorders; nephropathies, retinitis, disseminated encephalitis, arteritic decalcification and phlebitis.

B. Magnesium Orotate

Magnesium orotate, as an activator of direct oxidation in the pentose pathway, affects tissues dependent on the pathway, such as vascular walls, connective tissue, cartilage, etc., making it ideal for long-term therapy of arteriosclerosis.

Early studies on magnesium orotate (200-600 mg/daily) demonstrated that it is more efficient in the mobilization of cholesterol esters and in the activation of cholesterol turnover than other cholesterol activators tested.

A study in rats (120-130 mg-weight) with experimental hypertension induced by a cardiopathogenic diet showed that magnesium orotate in the diet (100 mg/day) prevented hypertension symptoms in one group and caused regression of them in the non-supplemented group if treated within 4 weeks. Myocardial damage was also least severe in the magnesium orotate-supplemented group. Similar results were not produced with orotic acid.

A biochemical investigation of 100 patients given either 200 or 400 mg of magnesium orotate daily showed a 32.06% reduction of plasma lipids from pre-treatment levels.

A cross-over double-blind study of the lipidemia-reducing effects of clofibrate as compared with clofibrate/magnesium orotate (9/1) showed that 450 mg clofibrate plus 50 mg magnesium orotate daily caused a faster drop in cholesterol and triglyceride levels than three separate daily doses of 450 mg of clofibrate alone.

1. Kavaform

Kavaform, a combination of kava (50 mg) and magnesium orotate (200 mg), was investigated in 300 patients with vascular cerebral disorders, traumatic brain damage, and post-brain surgery symptoms. Of the patients treated, 119 of 140 with brain trauma, 117 of 124 with vascular disorders, and all 36 of the post-brain surgery cases showed noticeable improvement with a single dose (50 mg kava, 200 mg Mg-orotate) during the treatment period (average — 50 days).

The use of Kavaform on 63 chronic psychiatric patients as an additional therapy produced favorable results in controlling anxiety and tension.

2. Vasotate

Vasotate, a product containing 300 mg of magnesium orotate in an enteric coated tablet, was recently evaluated in a clinical investigation of its effect on serum lipids.

The study monitored two groups of hyperlipidemic patients given 900 mg per day of magnesium orotate for three months. The first group of eight patients showed reductions of 15.2% in cholesterol and 32.4% in triglycerides. The second group (which included borderline hyperlipidemics with lower initial lipid levels) showed reductions of 5.9% and 25.0% in cholesterol and triglycerides respectively.

No side effects or adverse reactions were noted in any patients during the study.

The investigators concluded that magnesium orotate was safe and effective as adjunctive therapy in the reduction of cholesterol and triglycerides in hyperlipidemic patients.

It appears that orotic acid is a safe and effective carrier of minerals within the body and that the orotate salts have significant applications for use as adjunctive nutritional factors in a number of vascular and orthopedic conditions.

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